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Clinic Invoice

BoostExcel.com

Template#: c7041
Title: Clinic Invoice
Category: Receipt

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DR. ABC CLINIC

Address City, State ZIP Phone#, web address

				DATE:		
				INVOICE #:		
				INVOICE #:		
Phone						
Dt of Service	Description	Total Fee	Co-Pay	Ins Reim	Adj	Balance (PR)
						12.00
					TOTAL	-
		PAYMENT T	ERMS: NET 30	DAYS	IOIAL	
	PAYA	BLE BY CASH, CH				
		,				
	PLEASE RETURN	THIS PART WITH	YOUR CHECK	MADE PAYABLE TO	DR. xxx	
	Account No	:				
	Invoice Date:					
	Balance	:				
	Amount Enclosed:					
() PLEASE CHECK HI	ERE TO CHAN	GE ADDRES	SS AND PRINT CH	HANGES ABO	VE
		Th	nank you!			