

# Patient Medical Charges Invoice

**Invoice Number**

### Invoice Date

### Due Date

## Patient Information

Patient Name

### Patient ID

Date of Birth

## Contact

## Provider Information

Provider Name

### Facility/Clinic

## Contact

## Charge Details

### Subtotal

Tax \_\_\_\_\_

Other \_\_\_\_\_

**Total Amount Due** \_\_\_\_\_

---

---

Notes / Additional Information

---

---

---

Patient Signature

Date

---

Authorized Signature

Date

---