|  |  |  |
| --- | --- | --- |
| INVOICe |  | Logo placeholder |
| DATE  Date | INVOICE NO  Number | YOUR FACILITY  Street Address  City, ST ZIP Code  Phone  Fax  Email |
| CLIENT  Street Address  City, ST ZIP Code  Phone  Email |  |  |

| PSYCHIATRIST | PATIENT | Payment Terms | Due date |
| --- | --- | --- | --- |
| Psychiatrist Name | Patient Name | Payment Terms | Due Date |

| description | hours | $ / hour | amount |
| --- | --- | --- | --- |

|  |  |  |  |
| --- | --- | --- | --- |
| Description | Hours | $ | $Amount |
| Description | Hours | $ | $Amount |
| Description | Hours | $ | $Amount |
| Description | Hours | $ | $Amount |

| Subtotal |  |
| --- | --- |
| Discount |  |
| Sales Tax |  |
| Total |  |

|  |
| --- |
| **Comments:** Type comments |

Payment is due within \_\_\_ days.