CHIROPRACTIC INVOICE

CLINIC

Clinic name _____

Address _____

Phone / email _____

Chiropractor _____

License no. _____

INVOICE DETAILS

Invoice no. _____

Invoice date _____

Payment terms _____

Due date _____

Account no. _____

BILL TO (PATIENT)

Patient name _____ Email _____

Address _____

VISITS

Visit dates _____

Payment type _____ Insurance, if any _____

SERVICES

Date	Service	Code	Qty	Fee	Amount

HOW TO PAY

Accepted methods _____

Account name _____

Bank details _____

Payment reference _____

Subtotal	
Total	
Less: payment at visit	
Amount due	

BILLING NOTES

_____

_____

Please quote the invoice number with your payment.