SPEECH THERAPY INVOICE

PRACTICE

Business name _____

Address _____

Phone / email _____

Therapist _____

License no. _____

INVOICE DETAILS

Invoice no. _____

Invoice date _____

Payment terms _____

Due date _____

Account no. _____

BILL TO (CLIENT OR RESPONSIBLE PARTY)

Client name _____ Responsible party _____

Address _____

Email _____

SESSIONS

Session dates _____

Payment type _____

SERVICES

Date	Service	Code	Qty	Fee	Amount

HOW TO PAY

Accepted methods _____

Account name _____

Bank details _____

Payment reference _____

Subtotal	
Total	
Less: payment at session	
Amount due	

BILLING NOTES

_____

_____

Please quote the invoice number with your payment.