

INVOICE

Invoice No: _____
Date: _____
Due Date: _____

PATIENT INFORMATION

Patient Name: _____

Account No: _____

Phone: _____

RESPONSIBLE PARTY (IF MINOR)

Billing Name: _____

Address: _____

Email: _____

Orthodontic Treatment Overview

TOTAL TREATMENT FEE

TOTAL PAID TO DATE

INSTALLMENT PERIOD

REMAINING BALANCE

DESCRIPTION OF SERVICE / MONTHLY INSTALLMENT	TREATMENT MONTH	AMOUNT DUE
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Subtotal: _____

Late Fee (if applicable): _____

Total Due: _____

PAYMENT METHODS & POLICIES

Please present this statement at the time of payment or include your account number on your check.

Accepted Methods of Payment: Credit Card (Visa, MasterCard, Amex), Direct Debit, or Personal Check made payable to the clinic.

Payments received after the due date may be subject to a late administrative charge.

AUTHORIZED SIGNATURE

PATIENT / GUARANTOR SIGNATURE