|  |  |
| --- | --- |
| **SUB TOTAL** |  |
| **TOTAL** |  |

**THANK YOU!**



**MENTAL HEALTH**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DATE** | **HOURS** | **UNIT PRICE** | **QUANTITY** | **TOTAL** |
| 21.03.2019 | 2 | $30.00 | 3 | $90.00 |
| 22.03.2019 | 2 | $30.00 | 3 | $90.00 |
| 23.03.2019 | 2 | $30.00 | 3 | $90.00 |
| 24.03.2019 | 2 | $30.00 | 3 | $90.00 |
| 25.03.2019 | 2 | $30.00 | 3 | $90.00 |
| 26.03.2019 | 2 | $30.00 | 3 | $90.00 |

**INVOICE DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**





