***THANK YOU!***

**Terms and Condition:**

|  |  |
| --- | --- |
| **Other cost** |  $80.00 |
| **Labor cost** |  $185.00 |
| **Other** |  |
| **Tax** |  5% |
| **Total** |  $300.00 |

 **SUBTOTAL**  $400.00

|  |  |  |  |
| --- | --- | --- | --- |
| **DATE** | **HOURS/TASKS** | **RATE** | **AMOUNT** |
| 11.02.2019 | 2 | 40 | $80.00 |
| 12.02.2019 | 2 | 40 | $80.00 |
| 13.02.2019 | 2 | 40 | $80.00 |
| 14.02.2019 | 2 | 40 | $80.00 |
| 15.02.2019 | 2 | 40 | $80.00 |

Service Person:

Phone#:

**BILL TO:**

Name:

Address:

City, State, ZIP Code:

Phone:

**DATE:** 24, Aug, 2018

**INVOICE NO:** 5896

**Hospital Name**

**Doctor Name**

**Address**

**City, State, Zip code**

**Phone**

**Email**

**MENTAL HEALTH**

**INVOICE**





 

