INVOICE

TO:
Clinical Communications, L.P.
2900 Weslayan, Suite 310
Houston, Texas 77027-5109

Phone: (713) 627-9670
Fax: (713) 627-9680

FROM:

Phone:
Mobile:

_____
Invoicing Period

Date	Facility	Patient's Name (if applicable)	Hours Billed	Rate	Amount Due
					$

TOTAL AMOUNT DUE: $ _____

_____
Therapist's Signature Date