

YOUR LOGO

Your Tag Line

ABN: XXXXXXXXXX
ACN: XXXXXXXXXX

- XXXXXXXXXXXXXXXXXXXX
- XXXXXXXXXXXXXXXXXXXX
- XXXXXXXXXXXXXXXXXXXX
- XXXXXXXXXXXXXXXXXXXX

TAX INVOICE

Invoice Number : XXXXXXXXX

Date Issued : September 12, 2025
Due Date : Prepaid

Patient Information

Name : XXXXXXXXXXXXXXXX
Address : XXXXXXXXXXXXXXXX
Contact : XXXXXXXXXXXXXXXX

Description of Services Provided

Description	Qty	Unit Price (\$)	Total (\$)
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XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXX	1	0.00	0.00
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Subtotal \$0.00
Tax (10%) \$0.00

Total Amount Due \$0.00

Payment Instructions

Payment Method: Bank Deposit via EFT
BSB: XXXXX
Account Number: XXXXXXXXX
Please include the invoice number in your payment reference.

Terms & Conditions

- Please send remittance advice or any proof of payment to: XXXXXXXXXXXXXXXX
- Payment is due upon receipt of the invoice.
- If you have any questions regarding this invoice, please contact us.