INVOICE

Invoice No: INV-_____
Invoice Date: _____

BILL TO

Attorney / Firm Name: _____
Address: _____
City, State ZIP: _____
Phone / Email: _____

MATTER INFORMATION

Case / Matter Name: _____
File / Docket No: _____
Date of Service: _____
Retainer Applied: _____

PROFESSIONAL SERVICES

DATE	DESCRIPTION OF SERVICES	HOURS	RATE	AMOUNT

Services Subtotal: $_____

EXPENSES & REIMBURSABLE COSTS

DATE	EXPENSE DESCRIPTION	RECEIPT?	AMOUNT

Expenses Subtotal: $_____

Services Subtotal	$_____
Expenses Subtotal	$_____
Retainer Applied	($_____)
BALANCE DUE	**$_____**

Check
Make payable to:
Anchor Clinical Consulting, PLLC
Mail to: [Address on File]

ACH / Wire Transfer
Bank: [On File]
Routing: [On File]
Account: [On File]

Zelle
Send to:
nicole@anchorclinicalconsulting.com
Reference: Invoice No.

Invoices are due within 30 days. Balances unpaid after 30 days accrue interest at 1.5%/month. Questions? Contact nicole@anchorclinicalconsulting.com.

Thank you for your business and for trusting Anchor Clinical Consulting, PLLC.

It is our privilege to support excellence in legal advocacy through precision clinical analysis.