Physician: ____________________
C/O C. C. BILLING
3A - 2996 LONSDALE AVE.
NORTH VANCOUVER, BRITISH COLUMBIA
CANADA V7N 3J4

Phone: 604-929-9652
Fax: 604-929-9624

Date: ______________

DESCRIPTION OF SERVICES

FOR MEDICAL SERVICES PROVIDED BY **DR.** ______________________

RE: ____________________ ____________________ ____________________
Client's Surname **Given Name** **Birth date d/m/y**

________ ________ ________ ________ ________ ________ ________ ________
Apartment **Street Number** **Street Name** **City/Town** **Country** **Postal/Zip** **Area + Phone Number**

Date d/m/y	Fee Code / # of Services	$ Amount	Description of services	Time from/to

BALANCE DUE: **$ ____________ CANADIAN**

PAYMENT DUE WITHIN 30 DAYS

PLEASE NOTE THAT ANY FUNDS WHICH YOU HAVE PAID TO A HOSPITAL OR CLINIC, DO NOT INCLUDE FEES FOR MEDICAL SERVICES PROVIDED BY PHYSICIANS.
FOR CLIENTS NOT COVERED UNDER THE B.C. MEDICAL SERVICES PLAN, AND NON-RESIDENTS OF CANADA, IT IS THE CLIENT'S RESPONSIBILITY TO PROVIDE PAYMENT TO PHYSICIANS IMMEDIATELY UPON RECEIPT OF AN INVOICE. YOUR MEDICAL INSURANCE COMPANY WILL NOT BE BILLED DIRECTLY.

PAYMENT IN THE AMOUNT OF $____________ RECEIVED ON __________ (d/m/y)
VISA/MASTERCARD CARD NUMBER_______/_______/_______/_______/ 16 digits
CARDHOLDER'S NAME/ADDRESS/ PHONE (IF OTHER THAN ABOVE)______________________________

____

RELATIONSHIP TO ABOVE (IE: SPOUSE)____
CARD EXPIRY DATE: __________ (month/year)

PHYSICIAN'S SIGNATURE____________________ PATIENT'S SIGNATURE____________________

Please BLOCK PRINT