DERMATOLOGY CLINIC

123 Skin Care Blvd, Suite 400
Medical District, ST 12345
Phone: (555) 010-9988

INVOICE

Invoice #: [00000]
Date: [MM/DD/YYYY]

PATIENT INFORMATION

Name: [Patient Full Name]
ID: [Patient ID]
DOB: [MM/DD/YYYY]

BILLING SUMMARY

Insurance: [Provider Name]
Policy #: [Policy Number]
Due Date: [MM/DD/YYYY]

Service Date	CPT Code / Description	Provider	Amount
[Date]	99213 - Office Visit (Level 3)	Dr. [Name]	$0.00
[Date]	11102 - Tangential Biopsy of Skin	Dr. [Name]	$0.00
[Date]	Dermatopathology Lab Fee	Internal	$0.00

Subtotal: $0.00
Insurance Adjustment: ($0.00)
Copay Paid: ($0.00)

Balance Due: $0.00

Notes: Please include the invoice number with your payment. Payments are due within 30 days of receipt.

Thank you for choosing our specialized dermatology care.