

**[CLINIC NAME]**

[Street Address]  
[City, State, Zip]  
[Phone Number]

# INVOICE

Invoice #: \_\_\_\_\_  
Date: \_\_\_\_\_

---

**PATIENT INFORMATION**

**Name:** \_\_\_\_\_  
**ID/DOB:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_

**VISIT INFORMATION**

**Date of Service:** \_\_\_\_\_  
**Provider:** \_\_\_\_\_  
**Visit Type:** \_\_\_\_\_

| Service Description / Code | Qty | Unit Price | Amount |
|----------------------------|-----|------------|--------|
|                            |     |            |        |
|                            |     |            |        |
|                            |     |            |        |
|                            |     |            |        |

---

Subtotal: \$ \_\_\_\_\_  
Insurance Paid: (\$ \_\_\_\_\_)  
Balance Due: \$ \_\_\_\_\_

---

**NOTES & PAYMENT INSTRUCTIONS**

Please make checks payable to **[Clinic Name]**. Payment is due within 30 days of service. For billing inquiries, contact [Billing Department Email/Phone].