MEDICAL EXAMINATION SERVICES

[Clinic Name]
[Address Line 1]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

PATIENT INFORMATION

Name: _____
DOB: _____
ID/Policy #: _____

BILLING CONTACT

Name/Entity: _____
Address: _____
Email: _____

Date of Service	Description of Service / CPT Code	Qty	Unit Price	Amount

Subtotal: $_____
Tax/Adj: $_____

Total Due: $_____

Notes: _____

Payment Instructions: Please make checks payable to [Clinic Name]. For bank transfers, use Ref: [Invoice #].

Thank you for choosing our medical services.