OPHTHALMOLOGY CLINIC

123 Vision Blvd, Suite 400
Medical District, ST 12345
Phone: (555) 010-2020

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
DOB: _____
ID: _____

BILLING INFORMATION

Payer: _____
Insurance: _____
Policy #: _____

Service Date	Description / CPT Code	Qty	Unit Price	Total
	Comprehensive Eye Exam (92004)		$	$
	Optical Coherence Tomography (92133)		$	$
	Refraction (92015)		$	$

Service Date	Description / CPT Code	Qty	Unit Price	Total
	Frames / Lenses		$	$
	Other: _____		$	$

Subtotal: $ _____
Insurance Adjustment: ($ _____)
Tax: $ _____

Balance Due: $ _____

Notes: Payments are due within 30 days. Please make checks payable to "Ophthalmology Clinic". For billing inquiries, contact the office during business hours.

Thank you for trusting us with your vision.