ORTHOPEDIC SPECIALISTS

123 Medical Plaza, Suite 400
City, State, Zip
Phone: (555) 000-0000

INVOICE

Invoice #: ___________
Date: ___________
Due Date: ___________

BILL TO:

Name: ______________________
Address: ____________________
Phone: ______________________

INSURANCE DETAILS:

Provider: ___________________
Policy ID: ___________________
Group #: _____________________

Date of Service	CPT Code / Description	Qty	Unit Price	Total

Subtotal: $_______
Insurance Adjustment: ($______)
Copay Received: ($______)

Balance Due: $_______

Notes/Instructions: ____

Please make checks payable to: **Orthopedic Specialists**

Thank you for choosing our clinic for your orthopedic care.