INVOICE

[Medical Facility/Practice Name]
[Address Line 1]
[City, State, Zip]
[Phone Number]

INVOICE NUMBER #[00000]
DATE ISSUED [Month DD, YYYY]
DUE DATE [Month DD, YYYY]

PATIENT INFORMATION **[Patient Full Name]**
[Patient Address]
[City, State, Zip]
DOB: [MM/DD/YYYY]

INSURANCE DETAILS [Provider Name]
Policy: [Policy Number]
Group: [Group Number]

Service Date	Description / CPT Code	Units	Amount
[MM/DD/YY]	[Service Description Name]	[1]	$0.00
[MM/DD/YY]	[Service Description Name]	[1]	$0.00

Subtotal: $0.00
Insurance Paid: ($0.00)

Total Due: $0.00

PAYMENT INSTRUCTIONS

Please make checks payable to **[Practice Name]**. For bank transfers, use Account: [Number] Routing: [Number]. Reference Invoice #[00000].

Thank you for choosing our healthcare services.