

URGENT CARE CENTER

123 Medical Plaza, City, ST 12345
Phone: (555) 012-3456

INVOICE

Date: [Date]
Invoice #: [00000]

PATIENT BILLING:

[Patient Name]
[Address]
[City, State, Zip]
[Phone Number]

VISIT DETAILS:

Provider: [Physician Name]
Visit Date: [Date of Service]
Insurance: [Provider Name]

Service Code	Description	Qty	Unit Price	Total
99214	Office Visit - Level 4	1	\$0.00	\$0.00
87880	Rapid Strep Test	1	\$0.00	\$0.00
[CPT]	[Service Description]	1	\$0.00	\$0.00

Subtotal: \$0.00
Insurance Paid: (\$0.00)

Amount Due: \$0.00

Payment is due within 30 days of receipt.

Thank you for choosing Urgent Care Center for your healthcare needs.