

[Hospital Name]

[Street Address]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
ID: _____
DOB: _____

VISIT DETAILS

Department: _____
Physician: _____
Visit Date: _____

Description of Service	Code	Qty	Unit Price	Amount
Consultation Fee	[CPT Code]	1	\$	\$
Diagnostic Tests			\$	\$
Pharmacy / Medications			\$	\$
Other Services			\$	\$

Subtotal: \$ _____

Tax / Insurance Adjustment: \$ _____

Total Due: \$ _____

Payment Terms: Due upon receipt. Please make checks payable to [Hospital Name].

Authorized Signature: _____