ORTHOPEDIC SPECIALIST CLINIC

[Clinic Address Line 1]
[City, State, Zip]
Phone: (000) 000-0000
Email: clinic@example.com

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

PATIENT INFORMATION

Name: _____
ID/DOB: _____
Address: _____
Phone: _____

REFERRING PHYSICIAN / INSURANCE

Ref. Provider: _____
Insurance Co: _____
Policy #: _____
Auth #: _____

Service Date	CPT/Code	Description of Service / Procedure	Charge
		Consultation / Evaluation	$0.00
		Imaging (X-Ray/MRI)	$0.00
		Injections / Supplies	$0.00

Service Date	CPT/Code	Description of Service / Procedure	Charge
		Physical Therapy Assessment	$0.00

Subtotal: $0.00
Insurance Adjustment: ($0.00)
Paid to Date: $0.00
TOTAL DUE: $0.00

CLINICAL NOTES / DIAGNOSIS

ICD-10 Code(s): _____

Terms: Please include the invoice number with your payment. Payments are due within 30 days. Thank you for choosing our orthopedic services.