

[Clinic Name]

Pediatric Medical Center
[Address Line 1]
[Phone Number] | [Email]

INVOICE

Date: [DD/MM/YYYY]
Invoice #: [00000]

PATIENT INFORMATION

Name: [Child's Full Name]
DOB: [DD/MM/YYYY]
Parent/Guardian: [Name]

BILLING DETAILS

Insurance Provider: [Provider Name]
Policy #: [Number]
Consultation Date: [DD/MM/YYYY]

| Service Description | Code (ICD/CPT) | Amount |
|---------------------------------------|----------------|--------|
| Pediatric Consultation / Office Visit | [Code] | \$0.00 |
| Immunization / Vaccination | [Code] | \$0.00 |
| Laboratory Services | [Code] | \$0.00 |

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

Note: Payment is due within 30 days of the invoice date.

Thank you for trusting us with your child's care.