

PRIMARY CARE CLINIC

[Clinic Address Line 1]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____

PATIENT:

[Patient Name]
[Patient Address]
DOB: _____

PROVIDER:

[Practitioner Name]
NPI: _____
Tax ID: _____

Service Date	CPT Code / Description	Qty	Unit Price	Amount

Subtotal: \$ _____
Insurance Adjustment: (\$ _____)
Copay/Amount Paid: (\$ _____)
Total Balance Due: \$ _____

Payment Instructions: Please make checks payable to [Clinic Name]. Payments are due within 30 days of invoice date.

Diagnosis Codes (ICD-10): _____