# PEDIATRIC CARDIOLOGY CARE

[Practice Address Line 1]
[City, State, Zip]
Phone: (555) 000-0000

# INVOICE

Invoice #: _____
Date: _____

---

## PATIENT INFORMATION

**Name:** _____
**DOB:** _____
**Parent/Guardian:** _____

## BILLING INFORMATION

**Insurance Provider:** _____
**Policy Number:** _____
**Authorization #:** _____

| Service Date | CPT Code | Description of Service | Charge |
|---|---|---|---|
| | | Consultation / Office Visit | $ |
| | 93306 | Echocardiogram, Transthoracic | $ |
| | 93000 | Electrocardiogram (EKG) | $ |

| Service Date | CPT Code | Description of Service | Charge |
|---|---|---|---|
| | | | $ |

Subtotal: $ _____
Insurance Paid: $ _____
Amount Due: $ _____

**Payment Terms:** Please remit payment within 30 days. Make checks payable to "Pediatric Cardiology Care".

**Notes:** _____