

# Pediatric Gastroenterology Services

123 Medical Plaza, Suite 400  
City, State, Zip Code  
Phone: (555) 012-3456

## INVOICE

Invoice #: \_\_\_\_\_  
Date: \_\_\_\_\_

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### PATIENT INFORMATION

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_

### BILLING INFORMATION

Address: \_\_\_\_\_  
Insurance Provider: \_\_\_\_\_  
Policy #: \_\_\_\_\_

Service Date	CPT Code / Description	Qty	Unit Price	Total

Subtotal: \$ \_\_\_\_\_  
Insurance Paid: (\$ \_\_\_\_\_)  
Balance Due: \$ \_\_\_\_\_

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**Notes/Instructions:** \_\_\_\_\_

Please make checks payable to "Pediatric Gastroenterology Services". Payment is due within 30 days. Thank you for choosing us for your child's healthcare needs.