PEDIATRIC EYE CARE CLINIC

123 Vision Lane, Suite 400
Phone: (555) 010-9988
Email: billing@pediatriceye.com

MEDICAL INVOICE

Invoice #: _____

Date: _____

PATIENT INFORMATION

Name: _____

DOB: _____

Parent/Guardian: _____

INSURANCE DETAILS

Provider: _____

Policy #: _____

Group #: _____

Service Code/CPT	Description of Service	Provider	Amount
	Comprehensive Eye Exam (Pediatric)		$
	Cycloplegic Refraction		$
	Binocular Vision Assessment		$

Service Code/CPT	Description of Service	Provider	Amount
			$

Subtotal: $ _____
Insurance Adjustment: ($ _____)
Co-pay Paid: ($ _____)
Total Balance Due: $ _____

Notes: Follow-up scheduled for: _____

Please make all checks payable to "Pediatric Eye Care Clinic". Payments are due within 30 days of the invoice date. Thank you for choosing our practice for your child's eye health.