[Clinic Name]

[Address Line 1]
[City, State, Zip]
[Phone Number]
[License/Provider ID]

INVOICE

Invoice #: _____
Date: _____

BILL TO:

[Patient Name]
[Patient Address]
[Patient Phone]

TREATMENT DATE:

_____

Service/CPT Code	Description	Qty/Units	Rate	Amount
97810	Acupuncture, initial 15 min.			
97811	Acupuncture, addl. 15 min.			
99203	Office Visit / Evaluation			

Service/CPT Code	Description	Qty/Units	Rate	Amount
[Other]	[Herbs / Cupping / Other]			

Subtotal: $_____
Tax: $_____

Total: $_____

Notes / Diagnosis Codes (ICD-10): _____

Payment is due within [Number] days. Thank you for your business.