INVOICE

[Clinic Name]
[Address Line 1]
[Phone Number]

INVOICE # [000]
DATE: [MM/DD/YYYY]

PATIENT INFORMATION

[Patient Full Name]
[Patient ID / DOB]
[Address Line 1]

PROVIDER INFORMATION

[Doctor Name, D.C.]
[NPI Number]
[Tax ID / EIN]

Date of Service	CPT Code / Description	Qty	Rate	Amount
[Date]	99203 - Initial Exam	1	$0.00	$0.00
[Date]	98940 - Spinal Adjustment (1-2 regions)	1	$0.00	$0.00
[Date]	97014 - Electrical Stimulation	1	$0.00	$0.00

Subtotal: $0.00

Insurance Paid: ($0.00)
Balance Due: $0.00

Notes: [Payment terms or clinical notes]

Please make checks payable to [Clinic Name]. Thank you for choosing our practice for your wellness needs.