[Clinic Name]

[Clinic Address]
[Phone Number]
[Email/Website]

INVOICE

Invoice #: _____
Date: _____
Provider NPI: _____

PATIENT INFORMATION

Name: _____
ID: _____
Address: _____

PAYMENT STATUS

Method: [ ] Cash [ ] Card [ ] Insurance
Due Date: _____

Service Description	CPT Code	Qty	Unit Price	Amount
Initial Chiropractic Consultation	99203	1	$	$
Neuromuscular Examination	95851	1	$	$
Spinal Adjustment (1-2 Regions)	98940		$	$
X-Ray / Diagnostic Imaging	72040		$	$

Subtotal: $ _____
Insurance Adjustment: - $ _____
Total Amount Due: $ _____

Notes: _____

Thank you for choosing [Clinic Name] for your wellness needs. Payment is required at the time of service unless prior arrangements have been made.