CHIROPRACTIC CLINIC

123 Wellness Way
City, State, Zip
Phone: (555) 000-0000

INVOICE #: _____

DATE: _____

PATIENT:

_____
_____
_____

PRACTITIONER:

_____

Date of Service	ICD/CPT Code	Description of Treatment	Fee

SUBTOTAL: $ _____
INSURANCE CO-PAY: $ _____
TOTAL AMOUNT DUE: $ _____

Notes: _____

Payment is due at the time of service. Thank you for choosing our clinic for your spinal health.