[Clinic Name]
[Street Address]
[City, State, Zip]
[Phone Number] | [Tax ID/NPI]

INVOICE

Date: _____
Invoice #: _____

PATIENT:
Name: _____
ID/DOB: _____
Address: _____
REFERRING DOCTOR:
Name: _____
Provider ID: _____

Date of Service	CPT Code	Description of Imaging Service (X-Ray/MRI/CT)	Qty	Unit Price	Total

Subtotal: $_____
Insurance Adjustment: ($_____)

TOTAL DUE: $_____

Notes / Clinical Indications:

Payment is due within [Number] days. Please make checks payable to: **[Clinic Name]**

Thank you for choosing our diagnostic services.