Clinical Vision Therapy

[Clinic Address Line 1]
[City, State, Zip]
[Phone Number]
[Email/Website]

INVOICE

Invoice #: _____
Date: _____
Provider NPI: _____

PATIENT INFORMATION

Name: _____
DOB: _____
ID #: _____

BILLING INFORMATION

Responsible Party: _____
Address: _____
Insurance: _____

Date	CPT Code	Description of Service	Qty	Unit Price	Amount
	92060	Sensorimotor Examination			
	92065	Orthoptic/Vision Training Session			
	99213	Progress Evaluation (Level 3)			
		Home Therapy Equipment Kit			

Subtotal: $ _____
Insurance Adjustment: ($ _____)

Balance Due: $ _____

DIAGNOSIS CODES (ICD-10)

[ ] H51.11 Convergence Insufficiency [ ] H53.2 Diplopia [ ] H55.00 Nystagmus [ ] Other: _____

Payment Terms: Payment is due within 30 days of service. Please make checks payable to "Clinical Vision Therapy".

This document serves as an official medical invoice for vision therapy services rendered.