# OCULAR HEALTH INVOICE

Date: _____
Invoice #: _____

**PATIENT INFORMATION**

Name:

ID/DOB:

Contact:

**PROVIDER INFORMATION**

Optometrist/Ophthalmologist:

Clinic License:

Tax ID:

| SERVICE DESCRIPTION / PROCEDURE CODE | QTY | UNIT PRICE |
| --- | --- | --- |
| Comprehensive Eye Examination | | |
| Digital Retinal Imaging / OCT Scans | | |
| Visual Field Analysis | | |

| SERVICE DESCRIPTION / PROCEDURE CODE | QTY | UNIT PRICE |
| --- | --- | --- |
| Tonometry & Intraocular Pressure Check | | |
| Refraction & Prescription Update | | |
| Other: _____ | | |

Subtotal: $_____
Insurance Coverage: ($_____)
Total Balance Due: $_____

**CLINICAL NOTES / NEXT FOLLOW-UP**

Thank you for choosing our clinic for your ocular health needs.

Payment is due upon receipt of services.