VISION CARE & OPTICAL

123 Optometry Lane
City, State, Zip
Phone: (555) 000-0000

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____
ID: _____
Address: _____

PROVIDER INFORMATION

Doctor: _____
License #: _____
NPI: _____

CLINICAL EXAMINATION DETAILS

Service/Product Description	CPT/Code	Qty	Unit Price	Total
Comprehensive Eye Exam (New/Est)	_____	1	$	$
Refraction Service	92015	1	$	$
Retinal Imaging / Fundus Photography	_____	1	$	$

Service/Product Description	CPT/Code	Qty	Unit Price	Total
Frames / Lenses / Enhancements	_____	__	$	$
Contact Lens Fitting/Evaluation	_____	1	$	$

PRESCRIPTION SUMMARY (FINAL)

OD (Right)
Sph: _____
Cyl: _____
Axis: _____
OS (Left)
Sph: _____
Cyl: _____
Axis: _____

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

Thank you for choosing our vision care services.
Payments are due at the time of service. No returns on custom prescription lenses.