INVOICE

OPHTHALMOLOGY CLINIC NAME
123 Medical Plaza, Suite 400
City, State, Zip Code
Phone: (555) 000-0000

INVOICE # _____
DATE _____

PATIENT INFORMATION Name: _____
DOB: _____
ID: _____
Referring Physician: _____
BILLING INFORMATION Insurance: _____
Policy #: _____
Group #: _____

CPT CODE	DIAGNOSTIC DESCRIPTION	EYE (OD/OS/OU)	AMOUNT
92083	Visual Field Examination (Extended)		$
92133	Scanning Laser Polarimetry (OCT GDX)		$
92020	Gonioscopy		$
76514	Pachymetry (Corneal Thickness)		$
92250	Fundus Photography (Optic Nerve)		$
92100	Serial Tonometry		$

Subtotal: $ _____
Insurance Adjustment: $ _____

Patient Responsibility: $ _____

Notes/Observations:

_____

Payment is due within 30 days. Please make checks payable to the clinic name above.