INVOICE

[Clinic Name]
[Street Address]
[City, State, Zip]
[Phone Number]

Invoice #: _____
Date: _____

Patient Information:

Name: _____
ID: _____
Contact: _____

Provider Information:

Practitioner: _____
NPI Number: _____

CPT/Code	Procedure Description	Qty	Unit Price	Amount
92012/14	Eye Examination / Evaluation			
0312T	LipiFlow Thermal Pulsation (OD/OS)			
68761	Punctal Plug Insertion			
92285	External Ocular Photography (Tear Film)			
-	In-Office Meibomian Gland Expression			

CPT/Code	Procedure Description	Qty	Unit Price	Amount
-	IPL (Intense Pulsed Light) Therapy			

Subtotal: $_____

Insurance Coverage: ($_____)

Total Amount Due: $_____

Notes: _____

Payment Terms: Due upon receipt of services. Thank you for choosing our clinic for your ocular surface care.