EMERGENCY EYE CARE

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

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____
Date of Birth: _____
Insurance ID: _____

Service Code	Description of Emergency Service	Fee
992xx	Emergency Ophthalmic Evaluation	$ _____
92015	Refraction	$ _____
652xx	Foreign Body Removal (OD / OS / OU)	$ _____
92250	Fundus Photography / Imaging	$ _____
	Other: _____	$ _____

Subtotal: $ _____
Insurance Adjustment: - $ _____

Amount Due: $ _____

CLINICAL FINDINGS / NOTES

Emergency Optometric Services Provided by: _____ (Provider Signature)

Payment is due at the time of emergency services unless prior arrangements exist.