GERIATRIC VISION CARE

[Clinic Address Line 1]
[Clinic Address Line 2]
Phone: (555) 000-0000

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____
DOB: _____
Medicare/ID: _____

BILLING ADDRESS

_____
_____
_____

Service/Item Description	Qty	Unit Price	Amount
Comprehensive Eye Exam (Senior)			
Glaucoma Screening / Tonometry			
Retinal Imaging / Fundus Photo			
Frames & Prescription Lenses			

Service/Item Description	Qty	Unit Price	Amount
Home Visit/Mobile Unit Fee			

Subtotal: $_____

Insurance Coverage: ($_____)

Total Due: $_____

Payment due upon receipt. Please make checks payable to "Geriatric Vision Care".

Notes: _____