OPHTHALMOLOGY SERVICES

[Clinic Name]
[Address Line 1]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____
Patient ID: _____

PATIENT INFORMATION

[Patient Full Name]
[Patient Address]
[Phone Number]

INSURANCE DETAILS

Provider: [Insurance Name]
Policy #: [Number]
Group #: [Number]

Date of Service	CPT/HCPCS Code	Description of Service	Amount
		Comprehensive Eye Exam	$0.00
		Refraction	$0.00

Date of Service	CPT/HCPCS Code	Description of Service	Amount
		Diagnostic Imaging (OCT/Retinal)	$0.00

Subtotal: $0.00
Insurance Adjustment: ($0.00)
Copay/Deductible: $0.00

TOTAL DUE: $0.00

CLINICAL NOTES / REFERRALS

Please make checks payable to: [Clinic Name]

Payment is due within 30 days of the invoice date. Thank you for choosing our practice for your eye care needs.