INVOICE

[Practice Name]
[Address Line 1]
[Phone Number]
[NPI Number / Provider ID]

Date: _____
Invoice #: _____

Patient Information

Name: _____
ID / DOB: _____
Address: _____

Insurance Details

Carrier: _____
Policy #: _____
Auth #: _____

Service/CPT Code	Description	Fee	Insurance Paid	Patient Responsibility
	Comprehensive Eye Exam	$	$	$
	Contact Lens Fitting/Eval	$	$	$
	Frames / Lenses	$	$	$
	Retinal Imaging / Testing	$	$	$

Service/CPT Code	Description	Fee	Insurance Paid	Patient Responsibility
	Other: _____	$	$	$

Subtotal: $ _____
Insurance Discount: $ _____
Total Due: $ _____

Prescription Summary (For Reference)

OD (Right): SPH: _____ CYL: _____ AXIS: _____ ADD: _____
OS (Left): SPH: _____ CYL: _____ AXIS: _____ ADD: _____

Payment is due upon receipt. Thank you for choosing our professional optometry services.