PEDIATRIC OPTOMETRY

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

INVOICE

Date: [Date]
Invoice #: [00000]
Provider NPI: [Number]

PATIENT INFORMATION

[Patient Name]
DOB: [MM/DD/YYYY]
Parent/Guardian: [Name]

BILLING ADDRESS

[Street Address]
[City, State, Zip]

Service Description	CPT Code	Qty	Unit Cost	Amount
Comprehensive Vision Screening	99173	1	$0.00	$0.00
Automated Refraction Screening	99174	1	$0.00	$0.00
Ophthalmoscopy, Extended	92201	1	$0.00	$0.00

Subtotal: $0.00
Insurance Adjustment: ($0.00)

Total Balance Due: $0.00

Thank you for choosing us for your child's eye care.

Please make checks payable to [Clinic Name]. Payment is due within 30 days.