[Practice Name]

[Address Line 1]
[Address Line 2]
[Phone Number]
[Email/Website]

INVOICE

Date: [MM/DD/YYYY]
Invoice #: [00000]
Provider: [Doctor Name, O.D.]

BILL TO

[Patient Name]
[Patient Address]
[City, State, Zip]
[Patient ID / DOB]

INSURANCE INFORMATION

Provider: [Insurance Co. Name]
Policy ID: [Policy Number]
Auth Code: [Authorization #]

Service/Item Code	Description	Qty	Unit Price	Total
92014	Comprehensive Eye Exam - Established Patient	1	$0.00	$0.00
V2020	Frames / Prescription Eyewear	1	$0.00	$0.00

Service/Item Code	Description	Qty	Unit Price	Total
V2784	Polycarbonate Lenses	2	$0.00	$0.00
[Code]	[Additional Service/Co-pay/Product]	1	$0.00	$0.00

Subtotal: $0.00
Insurance Paid: ($0.00)
Tax: $0.00
Amount Due: $0.00

Thank you for choosing [Practice Name] for your vision care needs.

Payment is due at the time of service. We accept Cash, Credit Cards, and FSA/HSA.
Any balances remaining after insurance processing are the responsibility of the patient.