# INVOICE

Refractive Error Correction Services

**[Clinic Name]**

[Clinic Address]

[Phone/Email]

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**PATIENT:**

[Patient Name]

[Address]

[Contact Number]

**Invoice #:** [00000]

**Date:** [Date]

**Practitioner:** [Optometrist Name]

**Prescription Details**

| Eye | Sphere (SPH) | Cylinder (CYL) | Axis | Add |
|---|---|---|---|---|
| OD (Right) | | | | |
| OS (Left) | | | | |

| Service / Item Description | Qty | Unit Price | Total |
|---|---|---|---|
| Eye Examination & Refraction | 1 | $0.00 | $0.00 |
| Lenses ([Type: e.g., Single Vision, Progressive]) | 2 | $0.00 | $0.00 |
| Frame ([Brand/Model]) | 1 | $0.00 | $0.00 |
| Coatings ([Type: e.g., Anti-Reflective, Blue Light]) | - | $0.00 | $0.00 |

Subtotal: $0.00

Tax: $0.00

**Balance Due: $0.00**

**Notes:** All refractive products are custom-made to prescription. Please allow [X] days for processing.

**Payment Terms:** Due upon receipt. Thank you for choosing our clinic for your vision care.