CLINICAL PODIATRY INVOICE

[Clinic Name]
[Address Line 1]
[Phone Number]
[Provider Registration/NPI]

Invoice #: _____

Date: _____

PATIENT DETAILS:

[Patient Name]
[Patient Address]
[Date of Birth]

REFERRAL / INSURANCE:

[Referring Physician]
[Insurance Provider]
[Policy/Claim Number]

Date of Service	Procedure Code (CPT/ICD)	Description of Treatment	Amount

Subtotal: $_____
Tax: $_____

Total Due: $_____

Notes / Home Care Instructions:

_____

Payment Terms: Due upon receipt. Please make checks payable to [Clinic Name].

Thank you for choosing our clinic for your foot health.