PODIATRY INVOICE

Clinic Name: _____
License #: _____
Address: _____
Phone: _____

Invoice #: _____
Date: _____
Tax ID: _____

Patient Information:

Name: _____
DOB: _____
Address: _____
Phone: _____

Insurance/Billing:

Provider: _____
Policy #: _____
Auth #: _____
Referring MD: _____

Service Date	CPT/HCPCS Code	Description of Foot Care/Orthotics	Qty	Unit Cost	Total

Subtotal: $_____
Insurance Adjustment: ($_____)

Co-pay/Paid: $_____

Total Balance Due: $_____

Diagnosis/Notes: _____

Payment Terms: Due within 30 days. Please make checks payable to the clinic name listed above.

Thank you for choosing us for your foot health and mobility needs.