FOOT CARE INVOICE

Provider: [Clinic Name]
[Street Address]
[City, State, Zip]
[Phone/License Number]

Invoice #: _____
Date: _____

Patient Information:
Name: _____
DOB: _____
ID: _____

Service / Procedure Description	Code	Qty	Unit Price	Total
Comprehensive Diabetic Foot Exam				
Debridement of Hyperkeratotic Tissue				
Nail Debridement / Trimming				
Wound Care / Dressing Change				
Orthotic Assessment / Fitting				

Subtotal: $_____

Tax / Insurance Adj: $_____

Grand Total: $_____

Diagnosis/Notes: _____

Provider Signature: _____ **Date:** _____

Payment is due upon receipt. Thank you for your trust in our care.