FOOT & ANKLE SPECIALIST

[Clinic Name]
[Clinic Address]
[Phone Number]
[Tax ID/NPI]

INVOICE

Invoice #: [0000]
Date: [MM/DD/YYYY]

PATIENT:

[Patient Name]
[Address]
[Phone Number]
DOB: [MM/DD/YYYY]

INSURANCE / BILLING:

[Provider Name]
[Policy Number]
[Group Number]

Date of Service	CPT Code / Description	Qty	Unit Price	Total
[Date]	[e.g., 99213 - Office Visit]	1	$0.00	$0.00
[Date]	[e.g., Orthotic Fitting / X-Ray]	1	$0.00	$0.00

Date of Service	CPT Code / Description	Qty	Unit Price	Total

Subtotal: $0.00
Insurance Paid: ($0.00)

Balance Due: $0.00

Notes: [Diagnosis codes, Follow-up instructions, or Payment terms]

Please make checks payable to [Clinic Name]. Payment is due within 30 days.