[Practice Name]

[Podiatrist Name, DPM]
[Street Address]
[City, State, Zip]
[Phone Number] | [Email]

INVOICE

Invoice #: _____
Date: _____

PATIENT:

[Patient Full Name]
[Patient Address]
[Date of Birth]
[Insurance ID / Provider]

PAYMENT STATUS:

[ ] Insurance Pending
[ ] Private Pay
[ ] Co-pay Collected

Date of Service	CPT Code	Description of Podiatric Services	Amount

Subtotal: $_____
Insurance Adjustments: ($_____)
Tax (if applicable): $_____

Total Balance Due: $_____

Payment Terms:

Please make checks payable to **[Practice Name]**. Payment is due within 30 days of invoice date.

Note: This document serves as a medical invoice for podiatric care and orthotic supplies.