PODIATRIC MEDICINE CLINIC

[Clinic Address Line 1]
[City, State, Zip]
[Phone Number] | [Email/Website]

INVOICE

Invoice #: _____
Date: _____
NPI: _____

PATIENT INFORMATION

[Patient Name]
[Address]
[City, State, Zip]
DOB: _____

INSURANCE INFO / RESPONSIBLE PARTY

[Insurance Provider]
Policy #: _____
Group #: _____

Date of Service	CPT/HCPCS Code	Description of Services	Charges

Subtotal: $0.00
Insurance Adjustment: ($0.00)
Patient Co-pay: $0.00

Total Balance Due: $0.00

Notes/Diagnosis: _____

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

Thank you for choosing our podiatry services for your foot and ankle health.