[Clinic Name]

[Street Address]
[City, State, Zip]
[Phone Number]
[Tax ID/Provider Number]

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

Bill To:
[Patient Full Name]
[Patient Address]
[City, State, Zip]

Assessment Details:
Practitioner: [Name]
Referral Ref: [Number]
Date of Service: [Date]

Description of Services	Code	Qty	Unit Price	Total
Comprehensive Biomechanical Assessment	[Code]	1	$0.00	$0.00
Gait Analysis (Video/Digital)	[Code]	1	$0.00	$0.00
Custom Orthotic Casting/Scanning	[Code]	1	$0.00	$0.00
[Other Service/Item]			$0.00	$0.00

Subtotal: $0.00
Tax: $0.00
Total Due: $0.00

Payment Instructions: [Bank Name | Account Name | Account Number | Routing Code]

Terms: Please quote the invoice number for all payments. Interest may be charged on overdue accounts.

Thank you for choosing [Clinic Name] for your podiatric care.