# PODIATRY SPECIALIST CLINIC

123 Medical Plaza, Suite 400
Healthcare City, ST 12345
Phone: (555) 010-8899

# INVOICE

Invoice #: _____
Date: _____
Provider NPI: _____

## PATIENT INFORMATION

Name: _____
DOB: _____
ID: _____
Address: _____

## INSURANCE DETAILS

Carrier: _____
Policy #: _____
Group #: _____
Auth #: _____

| Date of Service | CPT Code | Description of Service | Amount |
|---|---|---|---|
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| | | | |
| | | | |

| Date of Service | CPT Code | Description of Service | Amount |
|---|---|---|---|
| | | | |
| | | | |

Subtotal: $_____
Insurance Paid: ($_____)
Co-pay: $_____
Balance Due: $_____

Please make checks payable to: **Podiatry Specialist Clinic**

Payment is due within 30 days of service. Thank you for choosing our specialized foot and ankle care.