[Podiatry Clinic Name]

[Street Address]
[City, State, Zip]
Phone: [Phone Number]
NPI: [Provider NPI Number]

INVOICE

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

PATIENT INFORMATION:

[Patient Full Name]
[Patient Address]
DOB: [MM/DD/YYYY]
ID: [Insurance ID Number]

INSURANCE PROVIDER:

[Payer Name]
[Group Number]
[Authorization #]

Date of Service	CPT/HCPCS Code	Description of Service	Charges
[MM/DD/YYYY]	[99213]	Office Visit (Established Patient)	$0.00
[MM/DD/YYYY]	[11721]	Debridement of Nails (6 or more)	$0.00

Date of Service	CPT/HCPCS Code	Description of Service	Charges
[MM/DD/YYYY]	[L3020]	Orthotic Insert, Custom Molded	$0.00

Subtotal: $0.00
Insurance Paid: ($0.00)
Adjustments: ($0.00)

Patient Responsibility: $0.00

Notes: [Standard foot care instructions or diagnostic notes]

Please make checks payable to **[Clinic Name]**. Thank you for choosing our practice for your foot health.