FERTILITY CARE CLINIC

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

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

BILL TO:

[Patient Full Name]
[Patient Address]
[Phone Number]
[ID/Reference Number]

PROVIDER:

[Specialist Name, MD/PHD]
[NPI Number/License #]
[Department/Suite]

Service Date	Description of Service / CPT Code	Qty	Unit Price	Amount
	Initial Fertility Consultation			
	Ultrasound - Follicular Study			

Service Date	Description of Service / CPT Code	Qty	Unit Price	Amount
	Laboratory Services / Hormonal Panel			
	Follow-up Review / Treatment Planning			

Subtotal: $_____
Insurance Adjustment: ($_____)
Total Balance Due: $_____

Payment Instructions: Please make checks payable to [Clinic Name]. For bank transfers, use Acc: [Number]. We accept all major credit cards.

Notes: This invoice serves as a formal request for payment for professional fertility services rendered. For insurance reimbursement claims, please use the attached Superbill.