FERTILITY CENTER

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

INVOICE

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

PATIENT INFORMATION

[Patient Full Name]
[Patient ID / Record #]
[Address Line 1]
[Address Line 2]

PAYMENT DETAILS

Due Date: [MM/DD/YYYY]
Cycle Type: [IVF / IUI / Storage]
Physician: [Doctor Name]

Description of Services / Medication	Quantity	Unit Price	Total
[Consultation / Ultrasound / Lab Work]	[0]	$0.00	$0.00
[Procedure / Cycle Fee]	[0]	$0.00	$0.00
[Medication / Anesthesia]	[0]	$0.00	$0.00
[Cryopreservation / Storage Fee]	[0]	$0.00	$0.00

Subtotal: $0.00
Insurance Adjustment: ($0.00)
Tax: $0.00

Balance Due: $0.00

Notes: [Insert payment instructions or insurance disclaimer here]

Thank you for choosing our center for your care.