INVOICE

[Clinic Name]
[Street Address]
[City, State, Zip]
[Phone Number]

Invoice #: _____
Date: _____
Cycle Ref: _____

BILL TO:

[Patient Name]
[Partner Name (Optional)]
[Address]
[City, State, Zip]

PAYMENT STATUS:

Due Date: _____
Method: _____

Service Description	Quantity	Unit Price	Total
Initial Consultation & Ultrasound			
Ovarian Stimulation Monitoring			
Oocyte Retrieval (Egg Collection)			
IVF Laboratory Processing / ICSI			

Service Description	Quantity	Unit Price	Total
Embryo Culture & Assessment			
Embryo Transfer Procedure			
Cryopreservation (Freezing)			
Medications / Pharmacy Fees			

Subtotal: $_____
Tax/Insurance Adj: $_____

Total Amount Due: $_____

Notes: Payments are required prior to the commencement of the next phase of the cycle. Please include the Invoice Number on all transfers.

Signature: _____