IUI TREATMENT INVOICE

[Clinic Name]
[Clinic Address]
[Phone Number]

Invoice #: _____
Date: _____

PATIENT INFORMATION

[Patient Full Name]
[Patient ID/DOB]
[Patient Address]
[Contact Number]

CYCLE DETAILS

Cycle Start Date: _____
Insemination Date: _____
Attending Physician: _____

Description of Service	Qty	Unit Cost	Total
Cycle Monitoring (Ultrasounds/Bloodwork)			
Sperm Processing & Preparation (Wash)			
Intrauterine Insemination Procedure			
Medications / Trigger Injection			
Lab/Administrative Fees			

Subtotal: $_____

Tax / Insurance Adjustments: $_____

Balance Due: $_____

Payment Terms: Payment is due within 30 days of service. Please make checks payable to [Clinic Name].

Notes: _____