REPRODUCTIVE MEDICINE CENTER

[Practice Address Line 1]
[City, State, Zip Code]
[Phone Number] | [Email/Website]

INVOICE

Date: _____
Invoice #: _____
Patient ID: _____

PATIENT INFORMATION:

[Patient Name]
[Address Line 1]
[Phone Number]

INSURANCE / GUARANTOR:

[Provider Name]
[Policy Number]
[Group Number]

Date of Service	CPT Code	Description of Services	Qty	Unit Price	Total
		Consultation / Ultrasound			
		Laboratory Fees (Hormonal Panels)			
		Procedure (IVF/IUI/Cryopreservation)			

Date of Service	CPT Code	Description of Services	Qty	Unit Price	Total
		Medications / Pharmacy Supplies			

Subtotal: $ _____
Insurance Adjustment: ($ _____)
Amount Paid: ($ _____)
BALANCE DUE: $ _____

Notes / Payment Instructions:

[Enter payment terms, wire transfer instructions, or financing plan details here]

Payment is due within [Number] days. Thank you for choosing our center for your reproductive healthcare.