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

IMAGING INVOICE

Invoice #: [00000]
Date: [MM/DD/YYYY]
Referring Physician: [Dr. Name]
Order ID: [Order #]

Patient Information:
[Patient Full Name]
[Date of Birth]
[Patient ID / MRN]
Insurance Details:
[Provider Name]
[Policy Number]
[Group Number]

CPT Code	Description of Ultrasound Service	Qty	Unit Price	Total
[Code]	[e.g., Abdominal Ultrasound - Complete]	1	$0.00	$0.00
[Code]	[e.g., Pelvic Ultrasound - Non-OB]	1	$0.00	$0.00

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

Amount Due: $0.00

Notes: [e.g., Payment due within 30 days. Please include Invoice # on check.]

Clinician Signature: _____