IMMUNOTHERAPY TREATMENT CENTER

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

INVOICE

Invoice #: ___________
Date: ___________
Patient ID: ___________

BILL TO:

[Patient Name]
[Patient Address]
[Phone Number]

INSURANCE INFORMATION:

Provider: ___________
Policy #: ___________
Group #: ___________

Date of Service	Description (Drug/Procedure/Lab)	Code (HCPCS/CPT)	Qty	Unit Cost	Total

Subtotal: $ ___________
Insurance Adjustment: ($ ___________)

Tax: $ ___________

Amount Due: $ ___________

Notes: All payments are due within 30 days of the invoice date. Please make checks payable to "Immunotherapy Treatment Center".

Thank you for choosing our facility for your care.