Children's Oncology Center

123 Care Lane, Medical District
Phone: (555) 010-9000

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____
DOB: _____
ID: _____

GUARANTOR/BILLING

Name: _____
Address: _____
Insurance: _____

Service Date	Description of Treatment/Medication	Code	Amount

Subtotal: $_____

Insurance Adjustment: ($_____)

Total Balance Due: $_____

Payment is due within 30 days. For financial assistance or payment plans, please contact our Patient Advocacy Office.

Thank you for trusting us with your child's care.