CLINICAL X-RAY SERVICES

123 Medical Plaza, Suite 400
Healthcare City, ST 12345
Phone: (555) 010-8888

INVOICE

Invoice #: _____
Date: _____
Order #: _____

PATIENT INFORMATION

Name: _____
ID: _____
DOB: _____

REFERRING PHYSICIAN

Dr. _____
Facility: _____
NPI: _____

CPT Code	Description of Imaging Service	Qty	Unit Price	Total

Subtotal: $0.00

Insurance Adjustment: ($0.00)
Balance Due: $0.00

Please include the invoice number with your payment.
Make all checks payable to **Clinical X-Ray Services**.
Thank you for choosing our diagnostic facilities.