DIAGNOSTIC RADIOLOGY CENTER

123 Medical Imaging Way
City, State, ZIP
Phone: (555) 010-9988

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION:

Name: _____
DOB: _____
ID/MRN: _____

BILLING DETAILS:

Referring Physician: _____
Insurance Provider: _____
Policy Number: _____

CPT CODE	DESCRIPTION OF SERVICE (X-Ray, MRI, CT, Ultrasound)	DATE OF SERVICE	AMOUNT

Subtotal: $ _____
Insurance Adjustment: $ _____
TOTAL DUE: $ _____

Payment Terms: Due within 30 days of invoice date. Please make checks payable to "Diagnostic Radiology Center".

Notice: This invoice reflects professional and/or technical components of radiological services rendered.