INVOICE

Imaging Center Name
123 Medical Drive
City, State, Zip

Invoice #: _____
Date: _____
Due Date: _____

Patient Information:

Name: _____
DOB: _____
ID: _____

Billing Address:

_____
_____
_____

Service Description	CPT Code	Qty	Unit Price	Total
Screening Mammography, Bilateral (2D)	77067	1	$0.00	$0.00
Digital Breast Tomosynthesis (3D)	77063	1	$0.00	$0.00
Radiologist Interpretation Fee	-	1	$0.00	$0.00
Facility Fee	-	1	$0.00	$0.00

Subtotal: $0.00
Insurance Paid: ($0.00)

Total Due: $0.00

Notes: Please include the invoice number with your payment. For billing inquiries, call (555) 000-0000.

Thank you for choosing our screening services.