MOBILE RADIOLOGY SERVICES

[Company Address Line 1]
[City, State, Zip]
[Phone Number]
[Email/Website]

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

BILL TO:

[Facility/Clinic Name]
[Billing Address]
[City, State, Zip]
Attn: [Accounts Payable]

PATIENT / SERVICE INFO:

Patient Name: _____
DOB: _____
Ordering Physician: _____
Location of Service: _____

Date of Service	Procedure / CPT Code	Description	Amount
		Mobile Transportation Fee	

Date of Service	Procedure / CPT Code	Description	Amount
		Reading/Interpretation Fee	

Subtotal: $0.00
Tax: $0.00

Total Due: $0.00

NOTES & PAYMENT INSTRUCTIONS:

Please make checks payable to: **[Company Name]**
Net [30] Days. A late fee may apply to overdue balances.
Thank you for choosing our mobile diagnostic services.