Pediatric Radiology Associates

123 Medical Plaza, Children's Wing
City, State, ZIP
Phone: (555) 000-0000

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
DOB: _____
ID #: _____

RESPONSIBLE PARTY / BILL TO

Name: _____
Address: _____
Insurance: _____

Date of Service	Procedure Code (CPT)	Description of Imaging Service	Amount

Date of Service	Procedure Code (CPT)	Description of Imaging Service	Amount

Subtotal: $ _____
Insurance Adjustment: $ _____
Total Balance Due: $ _____

Note: Professional interpretation and technical fees are included unless otherwise specified.

Please make checks payable to "Pediatric Radiology Associates". Payment is due within 30 days.