ULTRASOUND DIAGNOSTICS CLINIC

123 Medical Plaza, Imaging Suite 400
Healthcare City, ST 12345
Phone: (555) 012-3456

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
ID: _____
DOB: _____

BILLING / INSURANCE

Provider: _____
Policy #: _____
Referring MD: _____

Service Code / CPT	Description of Imaging Service	Qty	Unit Price	Total
_____	_____	____	$ _____	$ _____
_____	_____	____	$ _____	$ _____

Service Code / CPT	Description of Imaging Service	Qty	Unit Price	Total
_____	Facility Fee / Interpretation Fee	____	$ _____	$ _____

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

Notes: All payments are due within 30 days. Please include the invoice number with your payment.

Certification: This ultrasound examination was performed and interpreted by board-certified professionals.