[Dermatology Clinic Name]
[Street Address]
[City, State, Zip]
[Phone Number / NPI Number]

MEDICAL INVOICE

PATIENT INFORMATION
Name:

DOB:

ID/Policy #:

BILLING DETAILS
Invoice #:

Date of Service:

Provider:

CPT/ICD-10	Description of Procedure/Service	Qty	Unit Cost	Total

Subtotal: $
Insurance Adjustment: $
Copay/Coinsurance: $

Total Patient Balance: $
NOTES / DIAGNOSIS CODES

Payment is due upon receipt. Please make checks payable to the clinic name listed above.
Thank you for choosing our practice.