[Clinic Name]

[Address Line 1]
[City, State, Zip]
Phone: [000-000-0000]

Invoice #: _____

Date: _____

Provider: Dr. _____

PATIENT INFORMATION

Name: _____

ID: _____

DOB: _____

INSURANCE / BILLING

Carrier: _____

Policy #: _____

Authorization: _____

Service Code	Description of Service	Qty	Unit Price	Amount

Service Code	Description of Service	Qty	Unit Price	Amount

Subtotal: $ _____
Insurance Adjustment: - $ _____

Total Due: $ _____

Notes: _____

Please make checks payable to **[Clinic Name]**. Payment is due within 30 days of service.

Thank you for choosing our Family Medicine practice for your healthcare needs.