MEDICAL IMAGING CENTER

123 Diagnostic Way, Suite 100
Health City, ST 12345
Phone: (555) 010-8888

INVOICE

Invoice #: ___________
Date: ___________

PATIENT INFORMATION:
Name: ________________________
DOB: _________________________
ID: __________________________
REFERRING PHYSICIAN:
Dr. __________________________
NPI: _________________________

Service Date	CPT Code	Description of Imaging Service	Amount
			$
			$
			$

Subtotal: $__________
Insurance Adjustment: ($__________)
TOTAL DUE: $__________

Payment Terms: Due upon receipt. Please make checks payable to "Medical Imaging Center".

Notice: This document contains confidential medical information. If received in error, please destroy immediately.