DERMATOLOGY CLINIC

123 Medical Plaza, Suite 400
Healthcare City, ST 12345
Phone: (555) 010-8888

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION:

Name: _____
ID: _____
Address: _____

BILLING DETAILS:

Insurance: _____
Policy #: _____
Provider: _____

Service Description	Code (CPT)	Qty	Unit Price	Total

Subtotal: $_____
Tax / Fees: $_____
Insurance Paid: ($_____)

Total Due: $_____

Notes / Clinical Instructions:

Payment is due within 30 days. Please make checks payable to "Dermatology Clinic".

Thank you for choosing our clinic for your skincare needs.