PAIN MANAGEMENT SPECIALIST

[Clinic Name]
[Clinic Address]
[Phone Number]
[Tax ID / NPI]

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

PATIENT INFO:

[Patient Name]
[Address]
[Phone Number]
DOB: _____

INSURANCE INFO:

[Carrier Name]
Policy #: _____
Group #: _____

Date of Service	CPT Code	Description (Treatment/Injection/Consult)	Charges

Subtotal: $_____

Insurance Adjustment: -$_____

Insurance Paid: -$_____

Patient Co-pay/Co-insurance: $_____

Total Balance Due: $_____

Diagnosis (ICD-10): _____

Payment Instructions: Please make checks payable to [Clinic Name]. For credit card payments or billing inquiries, contact our billing office at [Phone Number].

Thank you for choosing our practice for your care.