MEDICAL CENTER NAME

123 Healthcare Blvd, Medical District
City, State, Zip Code
Phone: (555) 000-0000

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

PATIENT INFORMATION

Name: _____
ID: _____
DOB: _____

INSURANCE / BILLING

Provider: _____
Policy #: _____
Group #: _____

Date of Service	Description / CPT Code	Qty	Unit Price	Amount

Subtotal: $ _____
Insurance Adjustment: - $ _____

Total Patient Responsibility: $ _____

Notes: Please include the invoice number with your payment. Payments can be made via portal, mail, or phone.

Thank you for choosing our medical services.