INVOICE

PROTECTED HEALTH INFORMATION (PHI)

[Provider Name/Practice]
[Address]
[NPI Number / Tax ID]
[Phone Number]

PATIENT INFORMATION
Name: [Patient Name]
DOB: [MM/DD/YYYY]
ID: [Patient Account #]
Address: [Street, City, State, ZIP]

INVOICE DETAILS
Invoice #: [00000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

Date of Service	CPT/HCPCS Code	Description of Service	Unit Cost	Amount
[Date]	[Code]	[Description]	$0.00	$0.00
[Date]	[Code]	[Description]	$0.00	$0.00

Subtotal: $0.00

Insurance Paid: ($0.00)

Patient Responsibility: ($0.00)

Total Balance Due: **$0.00**

Payment Instructions: [Check/Credit Card/Portal Details]