INVOICE

[Facility Name]
[Street Address]
[City, State, Zip]
[Phone Number]

Invoice #: _____
Date: _____

PATIENT INFORMATION:
Name: _____
DOB: _____
ID#: _____

BILLING TO:
[Insurance Provider / Responsible Party]
Policy #: _____
Group #: _____

Date of Service	CPT/HCPCS Code	Description of Services	Charges

Subtotal: $_____

Insurance Adjustment: ($_____)

Patient Co-pay/Deductible: $_____

TOTAL BALANCE DUE: $_____

Please make checks payable to **[Facility Name]**.

Payment is due within [Number] days of the invoice date. For billing inquiries, call [Phone Number].