INVOICE

Invoice No: _____

Date: _____

Provider NPI: _____

PATIENT INFORMATION

Full Name:

DOB:

Address:

Phone:

INSURANCE DETAILS

Carrier:

Policy ID:

Group No:

Auth No:

DATE	CPT CODE	DESCRIPTION OF SERVICE / TREATMENT	UNITS	RATE ($)	TOTAL ($)

REMARKS / CLINICAL NOTES

Subtotal:	
Ins. Paid:	
Copay Received:	
Balance Due:	

Authorized Signature

Patient Signature (Consent to Bill)