Outpatient Billing Invoice

Provider Information

Provider Name:

Address:

Phone:

Patient Information

Patient Name:

Date of Birth:

Patient ID:

Invoice Number:
Date of Service:
Date Issued:

Services Rendered

Date	Description	Procedure Code	Quantity	Unit Price	Total

Subtotal	
Discounts/Adjustments	
Insurance Payment	
Amount Due	

Notes / Instructions:

Authorized Signature

Patient Signature