Healthcare Invoice

Date:

Invoice #:

Provider:

Provider Name / Clinic

Provider Address:

Street, City, State, ZIP

Contact:

Phone / Email

Billed To (Patient):

Patient Name

Patient Address:

Street, City, State, ZIP

Date of Birth:

Insurance Company:

Optional

Policy/ID #:

Optional

Other Details:

Optional

Service/Procedure	Code	Date	Qty	Rate	Amount
E.g. Consultation	CPT/ICD				

Subtotal

Tax

Discount

Total Due

Notes / Special Instructions:

Additional information, payment instructions, etc.

Authorized Signature:

_____

Date:

_____