

# Clinic Billing Statement Form

Patient Name

Patient ID / MRN

Date of Birth

Phone Number

Billing Date

Statement No.

Physician

## Services Rendered

Date	Service Description	CPT/Code	Quantity	Unit Price	Amount
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total Amount Due					<input type="text"/>

Insurance Provider

Policy No.

Notes / Comments

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date: \_\_\_\_\_  
Clinic Representative Signature

Date: \_\_\_\_\_