

# Your Business Name

# INVOICE

123 Your Street, City, State ZIP · you@business.com · (555) 123-4567

## FROM

## BILL TO

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Invoice #	Invoice date	Due date	Payment terms

CODE	DESCRIPTION / PROCEDURE	QTY	FEE	AMOUNT
e.g. 99213	Office visit — established patient, level 3	1	\$145.00	\$145.00
97110	Therapeutic exercise — 15 min unit	2	\$55.00	\$110.00
36415	Specimen collection — venipuncture	1	\$18.00	\$18.00

Subtotal \$273.00

Insurance adjustment - \$120.00

**PATIENT BALANCE DUE \$153.00**

## NOTES

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