INVOICE

[Your Business Name]
[Street address]
[City, State ZIP]
[email@yourbusiness.com]
[(555) 555-0123]

BILL TO

[Client Name]
[Street address]
[City, State ZIP]
[client@email.com]
Patient: [Patient name, date of birth]

Invoice number:	PT-1001
Invoice date:	10/27/2026
Due date:	11/26/2026
Terms:	Net 30
Provider NPI:	[10-digit NPI]
Diagnosis (ICD-10):	[Code]

SERVICE	UNIT PRICE	QUANTITY	AMOUNT
Office visit, established patient CPT 99214 · [date of service]	$165.00	1	**$165.00**
Electrocardiogram, 12-lead CPT 93000 · [date of service]	$60.00	1	**$60.00**
Blood draw CPT 36415 · [date of service]	$15.00	1	**$15.00**
Comprehensive metabolic panel CPT 80053 · [date of service]	$45.00	1	**$45.00**

NOTES/MEMO

Self-pay rates. This bill includes the codes your insurer needs if you wish to submit it for reimbursement. Billing questions: [phone].

Subtotal:	$285.00
Amount due:	**$285.00**