SURGICAL CONSULTATION INVOICE

[Practice/Surgeon Name]
[Medical License Number]
[Street Address]
[City, State, Zip]
[Phone Number]

Invoice #: _____
Date: _____
Due Date: _____

Patient Information:
Name: _____
DOB: _____
ID/Policy #: _____
Billing To:
[Insurance Carrier/Self-Pay Name]
[Billing Address]
[Claim Number if applicable]

Service Date	CPT Code	Description of Consultation Service	Charges
		Initial Pre-Surgical Consultation	$
		Diagnostic Review / Imaging Interpretation	$
		Administrative/Facility Fee	$

Subtotal: $_____

Insurance Adjustment: ($_____)

Total Balance Due: $_____

Payment Instructions: Please make checks payable to [Practice Name]. For wire transfers or credit card payments, please call the office.

Notes: This invoice represents professional fees for surgical consultation and evaluation only. Separate facility or anesthesia fees may apply for future procedures.