INVOICE

[Bariatric Center Name]
[Clinic Address]
[Phone Number]

Invoice #: _____
Date: _____

PATIENT INFO:

[Patient Name]
[Patient ID / DOB]
[Address]
[Phone]

SURGERY DETAILS:

Procedure: _____
Surgeon: _____
Date of Service: _____

Description of Service	CPT Code	Charges
Surgical Procedure Fee		$
Anesthesia Services		$
Facility / Operating Room Fees		$
Pre-operative Consultations		$
Post-operative Follow-up Care		$

Description of Service	CPT Code	Charges
Laboratory & Diagnostics		$

Subtotal: $ _____
Insurance Adjustment: ($ _____)

TOTAL DUE: $ _____

Payment Terms: Please remit payment within 30 days. Make checks payable to [Clinic Name].

Notes: CPT codes and itemized breakdown provided for insurance reimbursement purposes. For billing inquiries, contact [Billing Department Email/Phone].