DERMATOLOGY & SKIN SURGERY CENTER

[Practice Address Line 1]
[City, State, Zip]
Phone: (555) 000-0000

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____
DOB: _____
ID: _____

SURGICAL DETAILS

Surgeon: _____
Procedure Date: _____
Facility: _____

CPT Code	Description of Procedure / Pathology	Site/Laterality	Amount

Subtotal: $_____
Tax: $_____

Total Due: $_____

NOTES / POST-OPERATIVE CARE BILLING

_____

Terms: Payment due within 30 days. Please include the invoice number on your check.