INVOICE

[Clinic/Hospital Name]
[Address Line 1]
[City, State, Zip]
[Phone Number]

Invoice #: [000000]
Date: [Date]
Surgery Date: [Date]

BILL TO:

[Patient Name]
[Patient Address]
[City, State, Zip]
[Phone/Email]

SURGEON:

[Surgeon Name]
[Specialty]
FACILITY:
[Facility/Operating Room Name]

Description of Services / Procedure	CPT Code	Quantity	Unit Price	Total
[Primary Surgical Procedure Name]	[Code]	1	$0.00	$0.00
[Anesthesia Services]	[Code]	1	$0.00	$0.00

Description of Services / Procedure	CPT Code	Quantity	Unit Price	Total
[Facility Fees / OR Usage]	-	1	$0.00	$0.00
[Pre-Operative Consultation]	[Code]	1	$0.00	$0.00
[Post-Op Supplies/Medications]	-	1	$0.00	$0.00

Subtotal: $0.00
Insurance Adjustment: -$0.00
Deposit Paid: -$0.00

Total Balance Due: $0.00

Payment Terms: Due upon receipt or as per pre-surgical agreement.

Note: Elective procedures may not be covered by all insurance providers. Please verify coverage with your carrier.