INVOICE

Medical Facility Name
Surgery Center Address
Phone: (555) 000-0000

Invoice #: _____
Date: _____
Due Date: _____

PATIENT:

Name: _____
ID: _____
Address: _____

SURGEON / PROVIDER:

Dr. _____
NPI: _____
Specialty: Gastric Surgery

Service Description	CPT Code	Qty	Unit Price	Total
Gastric Procedure (Sleeve/Bypass)	_____	1	$	$
Anesthesia Services	_____	1	$	$
Facility / Operating Room Fee	_____	1	$	$

Service Description	CPT Code	Qty	Unit Price	Total
Pre-operative Consultations	_____	1	$	$
Post-operative Recovery Care	_____	1	$	$

Subtotal: $ _____
Insurance Adj: ($ _____)
Tax: $ _____

Total Due: $ _____

Notes: Please include the invoice number with your payment. Procedures related to ICD-10 Code: _____

Payment Terms: Payable via Check, Credit Card, or Bank Transfer. Payment is due within 30 days.