INVOICE

Facility Name / Medical Practice
Address Line 1
City, State, Zip
Phone: (000) 000-0000

Invoice #: _____
Date: _____

PATIENT INFORMATION:

Name: _____
ID/DOB: _____
Address: _____

SURGEON / PROVIDER:

Name: _____
NPI #: _____
Procedure Date: _____

Service Description / CPT Code	Qty	Unit Cost	Total
Minor Surgical Procedure: _____	____	$	$
Local Anesthesia / Supplies	____	$	$
Pathology / Lab Fees (if applicable)	____	$	$
Post-Operative Kit / Medication	____	$	$

Subtotal: $ _____
Tax: $ _____

Total Due: $ _____

Payment Terms: Due upon receipt. Please make checks payable to _____.

Notes: _____