NEUROSURGERY ASSOCIATES

123 Medical Plaza, Suite 400
Surgical Center City, ST 12345
Phone: (555) 010-9876

INVOICE

Invoice #: ___________
Date: ___________
Case ID: ___________

PATIENT INFORMATION

Name: ______________________
DOB: _______________________
ID: ________________________

PROCEDURE DETAILS

Surgeon: ____________________
Facility: _____________________
Date of Service: ______________

CPT Code	Description of Services	Qty	Unit Cost	Total
________	Surgical Procedure (Primary)	1	$ _____	$ _____
________	Assistant Surgeon Fees	1	$ _____	$ _____
________	Anesthesiology Services	1	$ _____	$ _____

CPT Code	Description of Services	Qty	Unit Cost	Total
__________	Neuromonitoring / Intraoperative	1	$ ______	$ ______
__________	Specialized Implants/Hardware	___	$ ______	$ ______

Subtotal: $ ___________
Insurance Adjustment: ($ __________)
Patient Balance Due: $ ___________

Payment is due within 30 days of invoice date.

Please make checks payable to **Neurosurgery Associates**.

Thank you for choosing our practice for your neurological care.