SURGICAL CENTER

123 Medical Plaza, Health City
Phone: (555) 000-1234

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____
DOB: _____
ID: _____

PROCEDURE DETAILS

Surgeon: _____
System: Robotic Platform Gen-X
Date of Surgery: _____

Description of Service / Consumable	Qty	Unit Price	Total
Robotic System Base Procedure Fee	1	$	$
Robotic Instrument Kit (Endowrist)		$	$
Anesthesia - Robotic Specialty		$	$
Operating Room - Hourly Rate		$	$

Description of Service / Consumable	Qty	Unit Price	Total
Sterile Robotic Drape & Supplies	1	$	$

Subtotal: $_____

Insurance Adjustment: ($_____)

Total Balance Due: $_____

Terms: Payment due within 30 days of procedure. Please include invoice number with payment.
This document serves as an itemized statement for robotic-assisted surgical services.