[HOSPITAL/CLINIC NAME]

[Street Address]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
DOB: _____
Patient ID: _____

PROCEDURE DETAILS

Date of Surgery: _____
Surgeon: _____
Facility ID: _____

Description (Code/Service)	Quantity	Unit Cost	Total
Surgical Suite / Operating Room Fee			
Anesthesia Services			
Surgeon Professional Fee			
Medical Supplies / Implants			
Post-Operative Recovery (PACU)			
Laboratory / Pathology			
Subtotal			$

Insurance Adjustment	($)
Insurance Paid	($)
PATIENT BALANCE DUE	**$**

Payment Terms: Please remit payment within 30 days. Make checks payable to [Hospital/Clinic Name].

For billing inquiries, please contact the financial services department at [Contact Info].