THORACIC SURGERY ASSOCIATES

123 Medical Center Way
Surgical Suite 400
Phone: (555) 010-9988

INVOICE

Date: _____
Invoice #: _____
Patient ID: _____

PATIENT INFORMATION:

Name: _____
Address: _____
Phone: _____

INSURANCE / GUARANTOR:

Provider: _____
Policy #: _____
Auth #: _____

CPT Code	Description of Services / Procedure	Qty	Unit Price	Total
_____	Initial Surgical Consultation	____	$ _____	$ _____
_____	Thoracoscopy / Video-Assisted (VATS)	____	$ _____	$ _____

CPT Code	Description of Services / Procedure	Qty	Unit Price	Total
_____	Anesthesia Services (Professional Fee)	____	$ _____	$ _____
_____	Post-Operative Inpatient Care (Days: __)	____	$ _____	$ _____
_____	Surgical Supplies / Pathology	____	$ _____	$ _____

Subtotal: $ _____

Insurance Adjustment: $ _____

Total Balance Due: $ _____

Notes: Payment is due within 30 days of invoice date. Please make checks payable to "Thoracic Surgery Associates".

This is a medical billing document. For clinical questions regarding your thoracic procedure, please contact the surgical coordinator.