# VASCULAR SURGERY CENTER

123 Medical Plaza, Surgical Suite 400
Healthcare City, ST 12345
Phone: (555) 010-9988

# INVOICE

**Invoice #:** _____
**Date:** _____
**Case ID:** _____

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## PATIENT INFORMATION

Name: _____
DOB: _____
ID: _____

## PHYSICIAN DETAILS

Surgeon: _____
Assistant: _____
Anesthesia: _____

## PROCEDURE DESCRIPTION

Primary Procedure:
_____

| CPT Code | Description of Services / Supplies | Amount |
|---|---|---|
| _____ | Surgical Suite & Facility Fee | $ _____ |
| _____ | Professional Surgeon Fee | $ _____ |
| _____ | Anesthesia Services | $ _____ |
| _____ | Imaging / Intraoperative Fluoroscopy | $ _____ |
| _____ | Vascular Graft / Stent / Consumables | $ _____ |

| CPT Code | Description of Services / Supplies | Amount |
|---|---|---|
| _____ | Recovery Room (PACU) | $ _____ |

Subtotal: $ _____
Insurance Adjustment: ($ _____)

**Total Balance Due: $ _____**

**Payment Terms:** Due upon receipt. Please make checks payable to "Vascular Surgery Center".

ICD-10 Diagnosis Codes: _____