

VETERINARY SURGICAL SPECIALISTS

[Clinic Address]
[Phone Number]
[Email/Website]

INVOICE

Invoice #: _____
Date: _____

CLIENT INFORMATION

Name: _____
Address: _____
Phone: _____

PATIENT INFORMATION

Patient Name: _____
Species/Breed: _____
Weight: _____ Case #: _____

SURGICAL PROCEDURE: _____

| Description of Services / Supplies | Qty | Unit Price | Amount |
|------------------------------------|-----|------------|--------|
| Pre-Anesthetic Blood Screening | | | |
| Anesthesia induction & Monitoring | | | |
| Soft Tissue Surgery: _____ | | | |
| Surgical Suite & Equipment Fee | | | |

| Description of Services / Supplies | Qty | Unit Price | Amount |
|--|-----|------------|--------|
| IV Catheter & Fluid Therapy | | | |
| Pain Management / Injectables | | | |
| Post-Operative Medications (Take-home) | | | |
| Histopathology / Lab Submission | | | |
| | | | |
| | | | |

Subtotal: \$ _____

Sales Tax: \$ _____

Total Amount: \$ _____

Deposit Paid: (\$ _____)

Balance Due: \$ _____

Post-Operative Instructions: Follow-up appointment required in ____ days for suture removal. Monitor incision site for redness, swelling, or discharge.

Payment is due at time of discharge. We accept Cash, Credit Cards, and [Other Payment Methods].