# FOOT & ANKLE SPECIALIST CLINIC

123 Medical Plaza, Surgical Suite 400
City, State, Zip Code
Phone: (555) 000-0000

## INVOICE

Invoice #: _____
Date: _____

**Patient Details:**

Name: _____
ID: _____
Address: _____

**Surgery Information:**

Surgeon: _____
Procedure Date: _____
Facility: _____

| CPT Code | Description of Services / Procedures | Amount |
|---|---|---|
| _____ | _____ | $ 0.00 |
| _____ | _____ | $ 0.00 |
| _____ | Anesthesia / Facility Fee (if applicable) | $ 0.00 |
| _____ | Post-Operative Supplies / Orthotics | $ 0.00 |

Subtotal: $ 0.00
Insurance Paid: $ 0.00

**Total Balance Due: $ 0.00**

**Payment Terms:** Please remit payment within 30 days. Checks payable to Specialist Foot Surgery Group.

**Tax ID:** XX-XXXXXXX | **NPI:** XXXXXXXXXX