SURGICAL PODIATRY CLINIC

123 Medical Plaza, Suite 400
Healthcare City, ST 12345
Phone: (555) 012-3456

INVOICE

Invoice #: _____
Date: _____
Surgery Date: _____

PATIENT INFORMATION

Name: _____
Address: _____
ID/DOB: _____

BILLING / INSURANCE

Carrier: _____
Policy #: _____
Authorization: _____

CPT Code	Description of Procedure / Service	Qty	Unit Cost	Total
_____	_____	____	$_____	$_____
_____	_____	____	$_____	$_____
_____	Post-Operative Supplies / Casting	____	$_____	$_____
_____	Facility / Anesthesia Fee (if applicable)	____	$_____	$_____

Subtotal:	$_____
Insurance Paid:	$_____
Balance Due:	**$_____**

Notes: Please include invoice number with payment. All post-operative follow-ups within 90 days are included in the surgical global period unless otherwise specified.

Provider: _____ (NPI: _____)