GASTROENTEROLOGY SPECIALISTS

123 Medical Plaza, Suite 400
City, State, Zip
Phone: (555) 012-3456

INVOICE

Invoice #: _____
Date: _____
Account #: _____

PATIENT INFORMATION

Name: _____
DOB: _____
Address: _____

PROCEDURE DETAILS

Attending Physician: _____
Facility Name: _____
Referring MD: _____

Date of Service	CPT Code	Description of Procedure / Service	Amount

Subtotal: $ _____
Insurance Paid: $ _____
Adjustment: $ _____

Total Amount Due: $ _____

PAYMENT INSTRUCTIONS

Please make checks payable to **Gastroenterology Specialists**. Include the account number on your check. Payments are due within 30 days of the invoice date.

This statement reflects the professional fees for your gastroenterology procedure. You may receive separate invoices from the surgical facility, anesthesiology group, or pathology laboratory.