OPHTHALMOLOGY SPECIALIST SURGERY

[Practice Address Line 1]
[City, State, Zip]
Phone: (555) 000-0000
Tax ID: 00-0000000

INVOICE

Invoice #: _____
Date: _____
Surgery Date: _____

PATIENT INFORMATION

Name: _____
DOB: _____
Patient ID: _____

INSURANCE / BILLING

Provider: _____
Policy #: _____
Auth #: _____

CPT Code	Description of Service / Procedure (Eye: L/R)	Qty	Unit Price	Total
_____	_____	____	$_____	$_____
_____	_____	____	$_____	$_____
_____	_____	____	$_____	$_____

CPT Code	Description of Service / Procedure (Eye: L/R)	Qty	Unit Price	Total
_____	Facility / Anesthesia Fee	____	$_____	$_____

Subtotal: $_____
Insurance Coverage: ($_____)
Patient Responsibility: $_____
Balance Due: $_____

Payment Terms: Payment is due within 30 days of surgery date. Please make checks payable to "Ophthalmology Specialist Surgery".

Notes: _____