ORTHOPEDIC SPECIALIST GROUP

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

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
ID: _____
DOB: _____
Phone: _____

CONSULTATION DETAILS

Surgeon: _____
Referring MD: _____
Facility: _____
Insurance: _____

CPT Code	Description of Service	Qty	Unit Price	Total
99204	Office consultation, new patient (Complex)	1	$	$
73562	X-ray, Knee; minimum 3 views		$	$
20610	Arthrocentesis, major joint/bursa (Injection)		$	$
			$	$

Subtotal: $ _____

Insurance Adjustment: ($ _____)
Patient Copay/Coinsurance: $ _____
Total Amount Due: $ _____

NOTES / TREATMENT PLAN

Please make all checks payable to Orthopedic Specialist Group.
Payment is due within 30 days of the invoice date. Thank you.