Surgery Medical Bill Form

Patient and Procedure Information

Full Name: _____

Date of Birth: _____

Patient ID: _____

Surgery Type: _____

Date of Surgery: _____

Surgical Facility: _____

Cost Breakdown

Service/Item	Quantity	Unit Cost	Total Cost
Surgery Fees			
Anesthesia Charges			
Operating Room Fees			
Post-Surgery Care			

Total Costs

Total Amount: _____

Insurance Coverage: _____

Patient Responsibility: _____

Acknowledgment

☐ **I agree to the charges and authorize the healthcare facility to process this bill for insurance reimbursement.**

Patient Name: _____

Signature: _____

Date: _____