

# SURGICAL EXPENSE RECORD

Date: \_\_\_\_ / \_\_\_\_ / 20\_\_\_\_

Patient Name: \_\_\_\_\_

Procedure: \_\_\_\_\_

Facility: \_\_\_\_\_

Surgeon: \_\_\_\_\_

DESCRIPTION OF SERVICE	BILLED AMOUNT	INSURANCE PAID	OUT OF POCKET
Pre-Admission Testing / Labs	\$	\$	\$
Surgeon Professional Fee	\$	\$	\$
Anesthesia Services	\$	\$	\$
Hospital / Facility Room Use	\$	\$	\$
Medical Supplies / Implants	\$	\$	\$
Post-Op Medications	\$	\$	\$
Physical Therapy / Recovery	\$	\$	\$
<b>TOTAL EXPENDITURE</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>

Additional Notes (Insurance claims, reference numbers, or follow-up billing dates):