

INVOICE

	Invoice #: Date of Service:			
Го:				
	For:			
Name:	Patient Name:			
Address:	MRN:			
	_			
EXAM TYPE AND MEDICAL RECORD DESCRIPTION	Charged Amount	Total Contrast	AMOUNT	

DESCRIPTION	KD	Charged Amount	Contrast	AMOUNT
US, CP	т			\$
			TOTAL:	

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Make all checks payable to Weill Cornell Imaging at NewYork-Presbyterian

Thank you for your business!

Reviewed: February 2025