Pediatric Neurology Clinic

123 Medical Plaza, Suite 400
Healthcare City, ST 12345
Phone: (555) 010-8899

INVOICE

Invoice #: ___________
Date: ___________
Due Date: ___________

PATIENT INFORMATION

Name: ___________________________
DOB: ____________________________
Parent/Guardian: _________________

BILLING DETAILS

Insurance Provider: _______________
Policy Number: ___________________
Auth Code: ______________________

Date of Service	CPT Code / Description	Provider	Charges
	Initial Consultation / Neuro Exam		$
	EEG Monitoring (Routine)		$
	Developmental Screening		$
			$

Subtotal: $ ________
Insurance Adjustment: ($ ________)
Copay/Amount Paid: ($ ________)

Total Balance Due: $ ________

Notes: Please include the invoice number with your payment. We accept major credit cards, checks, and HSA/FSA cards.

Thank you for choosing our clinic for your child's neurological care.