# ADVANCED NEUROLOGY CONSULTATION

123 Neuro Drive, Suite 400
Medical District, NY 10001
Phone: (555) 010-9988

## INVOICE

Date: _____
Invoice #: _____
Patient ID: _____

### PATIENT INFORMATION

Name: _____
DOB: _____
Address: _____
Phone: _____

### BILLING DETAILS

Insurance Carrier: _____
Policy Number: _____
Referring Physician: _____
Authorization #: _____

| CPT/Service Code | Description of Neurological Service | Qty | Unit Cost | Total |
|---|---|---|---|---|
| 99205 | Comprehensive Neurological Evaluation | 1 | $0.00 | $0.00 |
| 95819 | EEG - Digital Analysis/Extended | 1 | $0.00 | $0.00 |

| CPT/Service Code | Description of Neurological Service | Qty | Unit Cost | Total |
|---|---|---|---|---|
| 95910 | Nerve Conduction Studies (7-10 studies) | 1 | $0.00 | $0.00 |

Subtotal: $0.00
Insurance Adjustment: ($0.00)
Balance Due: $0.00

**Notes:** Payment is due within 30 days of service. Please include the invoice number on your check or electronic transfer. For billing inquiries, contact the Neuro-Billing Department at billing@advneurology.example.com.

*This document serves as an official clinical invoice for neurological services rendered.*