CLINICAL NEUROLOGY

[Clinic Name]
[Provider Name, MD/DO]
[NPI Number] | [Tax ID]
[Address Line 1]
[City, State, Zip]

INVOICE

Invoice #: [00000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

PATIENT INFORMATION

[Patient Name]
DOB: [MM/DD/YYYY]
ID: [Patient ID/Chart #]
[Patient Address]

BILLING REPRESENTATIVE / INSURANCE

[Insurance Carrier]
Policy #: [Policy Number]
Group #: [Group Number]
[Billing Contact Name]

Date of Service	CPT/HCPCS Code	Description of Service	Charge
[MM/DD/YYYY]	[Code]	Neurological Consultation (Initial/Follow-up)	$0.00
[MM/DD/YYYY]	[Code]	Electroencephalogram (EEG) / EMG / Nerve Study	$0.00

Date of Service	CPT/HCPCS Code	Description of Service	Charge
[MM/DD/YYYY]	[Code]	Neuropsychological Assessment	$0.00

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

NOTES & PAYMENT INSTRUCTIONS

Please make all checks payable to **[Clinic Name]**. Include the invoice number on your check. For credit card payments or billing inquiries, please contact our office at [Phone Number] or visit [Website].

Thank you for choosing our practice for your neurological care.