# Dr. [Consultant Name]

MBBS, MD, FRCP (Neurology)
Consultant Neurologist
Registration No: [Number]

# INVOICE

Invoice #: [0000]
Date: [DD/MM/YYYY]

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**Patient Details:**
Name: [Patient Name]
DOB: [DD/MM/YYYY]
ID: [Patient ID]
**Billing To:**
[Name/Insurance Provider]
[Address Line 1]
[Policy Number]

| Service Date | Description of Services / ICD-10 Code | Fee |
|---|---|---|
| [Date] | Initial Neurological Consultation | [0.00] |
| [Date] | Electromyography (EMG) / Nerve Conduction Study | [0.00] |
| [Date] | EEG Interpretation | [0.00] |

Subtotal: $[0.00]

Tax: $[0.00]

**Total Amount Due: $[0.00]**

**Payment Instructions:** Bank: [Name] | Account: [Number] | Sort Code: [Code]

*Please use the Invoice Number as a reference for payment. Due within [30] days.*

Clinic Address: [Address] | Phone: [Phone] | Email: [Email]