Diagnostic Neurology Consultation

[Practice Name]
[Medical License Number]
[Street Address]
[Phone Number]

INVOICE

Date: [Date]
Invoice #: [0000]
Case ID: [Reference]

PATIENT INFORMATION

[Patient Full Name]
DOB: [MM/DD/YYYY]
ID: [Patient ID/MRN]

REFERRING PHYSICIAN

[Doctor Name]
[Facility/Department]
NPI: [Number]

Service Description / CPT Code	Date of Service	Fee
Initial Neurological Consultation ([CPT])	[Date]	$0.00
Electromyography (EMG) - [Site]	[Date]	$0.00
Nerve Conduction Study (NCS)	[Date]	$0.00

Service Description / CPT Code	Date of Service	Fee
EEG Interpretation & Report	[Date]	$0.00

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

Payment Terms: Net 30 days. Please include Invoice Number on checks.

Diagnosis Codes (ICD-10): [Code 1], [Code 2]

This document contains confidential medical information protected by HIPAA.