NEUROLOGY CONSULTATION

[Clinic Name / Physician Name]
[License Number]
[Address Line 1]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
DOB: _____
Patient ID: _____

BILLING DETAILS

Insurance Carrier: _____
Policy Number: _____
Referral MD: _____

CPT Code	Description of Services	Units	Amount
_____	Neurological Consultation / Evaluation	___	$ _____
_____	Diagnostic Testing (EEG/EMG/NCV)	___	$ _____
_____	Imaging Review / Interpretation	___	$ _____

CPT Code	Description of Services	Units	Amount
_____	Follow-up Assessment	___	$ _____

Subtotal: $ _____

Insurance Adjustment: ($ _____)

Copay/Balance Paid: ($ _____)

Total Due: $ _____

Notes / Diagnosis Codes (ICD-10): _____

Payment is due within 30 days of the invoice date. Please include the invoice number on your check or electronic transfer.

Thank you for choosing our specialized neurological care.