NEUROLOGY DEPARTMENT

[Hospital Name]
[Medical Center Address]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____

PATIENT & PHYSICIAN INFORMATION

Patient Name: _____
Patient ID: _____
Date of Birth: _____
Attending Neurologist: _____
License No: _____
Referral Ref: _____

Service Description / CPT Code	Units	Unit Price	Amount
Initial Neurology Consultation			
EEG / Diagnostic Imaging			

Service Description / CPT Code	Units	Unit Price	Amount
Neuropsychological Assessment			
Laboratory Services			

Subtotal: $_____
Insurance Adjustment: ($_____)
Total Due: $_____

CLINICAL NOTES / REMARKS

Please make checks payable to **[Hospital Name]**.

Payment is due within 30 days of the invoice date. Thank you.