NEUROLOGY INVOICE

[Consultant Name, MD/DO]
[Medical License Number]
[Clinic Address]
[Phone Number] | [Email]

Invoice #: [00000]
Date: [Date]
Due Date: [Date]

Bill To:

[Patient Name / Insurance Company]
[Policy/ID Number]
[Address]
[Contact Info]

Patient Details:

DOB: [Date of Birth]
Ref. Physician: [Name]
Date of Service: [Date]

CPT Code	Description of Service	Rate	Total
[99204]	Neurological Consultation (Complex)	$0.00	$0.00
[95819]	EEG - Diagnostic Interpretation	$0.00	$0.00
[95910]	Nerve Conduction Studies	$0.00	$0.00

Subtotal: $0.00

Adjustments/Insurance: ($0.00)

Balance Due: $0.00

Payment Instructions: Please make checks payable to [Name] or pay via [Bank Transfer Details].

Notes: Diagnosis Code (ICD-10): [Code]. This is an independent consultation invoice. Confidential medical information.