NEUROLOGY CONSULTATION

[Clinic Name]
[Street Address]
[City, State, Zip]
[Phone Number] | [Email]

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
ID/DOB: _____
Address: _____

REFERRING PHYSICIAN

Name: _____
NPI #: _____
Reason: _____

CPT Code	Description of Services	Date	Fee
99204	Neurological Consultation - New Patient (Level 4)		$0.00
95819	Electroencephalogram (EEG) Professional Component		$0.00
95910	Nerve Conduction Studies (7-8 studies)		$0.00

CPT Code	Description of Services	Date	Fee

Subtotal: $0.00
Insurance Adjustment: ($0.00)

TOTAL DUE: $0.00

NOTES & DIAGNOSIS CODES (ICD-10)

Primary Diagnosis: _____

Please make all checks payable to [Clinic Name]. Payment is due within 30 days.
Thank you for choosing our specialized neurological care.