NEUROLOGY CONSULTATION

[Clinic Name]
[Address Line 1]
[Phone Number]

Invoice #: _____
Date: _____

PATIENT INFORMATION:

[Name]
[Date of Birth]
[Patient ID]

REFERRING PHYSICIAN:

[Doctor Name]
[NPI Number]

CPT Code	Description of Service	Qty	Unit Cost	Total
99204	New Patient Neurological Consultation	1	$0.00	$0.00
95819	EEG (Electroencephalogram)			
95910	Nerve Conduction Studies (7-8 studies)			
	Other: _____			

Subtotal:	$0.00
Insurance Adjustment:	($0.00)
Amount Due:	**$0.00**

Diagnosis (ICD-10): _____

Notes: Payments are due within 30 days. Please include invoice number on checks.