NEUROLOGY SPECIALISTS

[Clinic Address Line 1]
[City, State, Zip]
Phone: (555) 000-0000

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
ID: _____
DOB: _____

CONSULTATION INFO

Referring Physician: _____
Provider: _____
Date of Service: _____

CPT Code	Description	Amount
99214	Neurology Follow-Up (Level 4 - Moderate Complexity)	$ 0.00
95819	EEG Routine (If performed)	$ 0.00
	Refill Authorization / Coordination of Care	$ 0.00

Subtotal: $ 0.00
Insurance Paid: ($ 0.00)
Balance Due: $ 0.00

Diagnosis Codes (ICD-10): _____

Notes: Next follow-up appointment scheduled for _____.

Payment is due within 30 days. Thank you for choosing Neurology Specialists.