# Neurology Associates

123 Medical Plaza, Suite 400
City, State, Zip
Phone: (555) 000-0000

# INVOICE

Invoice #: _____
Date: _____
Provider NPI: _____

**PATIENT INFORMATION**

Name: _____
DOB: _____
ID: _____

**INSURANCE / RESPONSIBLE PARTY**

Carrier: _____
Policy #: _____
Group #: _____

| Date of Service | CPT/HCPCS Code | Description of Neurological Service | Amount |
|---|---|---|---|
| | | Outpatient Consultation (Level: ___) | |
| | | Diagnostic Testing (EEG/EMG) | |
| | | Interpretation & Report | |

Subtotal: $_____

Insurance Paid: ($_____)
Balance Due: $_____

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**Payment Terms:** Due upon receipt. Please make checks payable to "Neurology Associates".

**Diagnosis Codes (ICD-10):** _____