Pediatric Neurology Associates

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

INVOICE

Invoice #: _____
Date: _____

Patient Information:

Name: _____
DOB: _____
Guardian: _____

Billing Information:

Policy ID: _____
Provider NPI: _____
Ref. Physician: _____

Service Date	CPT Code / Description	Qty	Unit Cost	Total
	Initial Neurological Consultation			
	EEG Interpretation / Diagnostic			
	Developmental Screening			

Subtotal: $_____

Insurance Adjustment: ($_____)

Total Due: $_____

Payment Terms: Due within 30 days. Please make checks payable to "Pediatric Neurology Associates".

Notes: _____