[Practitioner Name / Clinic Name]

Neurology Specialist
[Medical License Number]
[Clinic Address Line 1]
[City, State, Zip Code]

Invoice #: _____
Date: _____

Bill To:

[Patient Name]
[Patient Address]
[Phone Number]
[Date of Birth]

Referring Physician: _____
Consultation Type: _____
Payment Terms: Due on Receipt

Service Code	Description of Service	Date	Amount
[CPT/ICD]	Initial Neurological Consultation	[Date]	$ 0.00
[CPT/ICD]	Diagnostic Procedure (e.g., EEG, EMG)	[Date]	$ 0.00
[CPT/ICD]	Follow-up Assessment	[Date]	$ 0.00

Subtotal: $ 0.00

Tax / Adjustments: $ 0.00

Total Balance Due: $ 0.00

Payment Instructions: [Bank Name] | **Account:** [Number] | **SWIFT/IBAN:** [Code]

Please include the Invoice Number as a reference for all transfers.

This document serves as an official medical invoice for insurance reimbursement purposes.