NEUROLOGY SERVICES

[Clinic Name]
[Medical License Number]
[Address Line 1]
[Phone / Email]

INVOICE
Date: [Date]
Invoice #: [0000]
Patient ID: [PT-000]

Patient Information:

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

Referral / Insurance:

Referring Physician: [Name]
Insurance Provider: [Provider]
Policy Number: [Number]

CPT Code	Description of Service	Qty	Unit Cost	Total
[99204]	New Patient Consultation - Complex	1	$0.00	$0.00
[95819]	EEG - Standard Awake/Sleep	1	$0.00	$0.00
[95910]	Nerve Conduction Study (7-8 studies)	1	$0.00	$0.00
Subtotal:			$0.00	
Insurance Adjustment:			($0.00)	
Total Due:			**$0.00**	

Notes & Payment Instructions:

Payment is due within [30] days. Please include the invoice number on your check or electronic transfer. For medical necessity documentation or diagnostic reports, please contact the records department.