NEUROLOGY & NEUROSCIENCES

[Doctor Name], MD, PhD
[Medical License Number]
[Clinic Address Line 1]
[City, State, Zip]

INVOICE

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

PATIENT INFORMATION

[Patient Full Name]
[Address Line 1]
[City, State, Zip]
DOB: [MM/DD/YYYY]

CONSULTATION DETAILS

Referring Physician: [Name]
Procedure Date: [Date]
Facility: [Clinic/Hospital Name]

Service Description (CPT Code)	Qty/Units	Unit Price	Amount
Initial Neurological Consultation (99205)	1	$0.00	$0.00
EEG Interpretation / Clinical Review	1	$0.00	$0.00

Service Description (CPT Code)	Qty/Units	Unit Price	Amount
Comprehensive Neuro-Cognitive Assessment	1	$0.00	$0.00

Subtotal: $0.00
Insurance Adjustment: ($0.00)
Total Balance Due: $0.00

Payment Terms: Due within 30 days. Please make checks payable to "[Clinic Name]".
Diagnoses (ICD-10): [Code 1], [Code 2], [Code 3]
This document serves as an official medical invoice for neurology services provided.