NEUROLOGY INVOICE

Invoice #: _____
Date: _____

Specialist Neurology Associates
Medical Chambers, Suite 402
City, State, Zip Code
Phone: (555) 000-0000
Tax ID: 00-0000000

PATIENT INFORMATION

Name: _____
DOB: _____
Patient ID: _____
Address: _____

REFERRAL DETAILS

Referring Physician: _____
Provider NPI: _____
Authorization #: _____
Claim #: _____

Date of Service	CPT Code	Description of Services	Amount
		Neurological Consultation (Initial/Follow-up)	$ 0.00
		Electroencephalogram (EEG)	$ 0.00
		Electromyography (EMG) / NCS	$ 0.00
		Cognitive Function Assessment	$ 0.00

Subtotal: $ 0.00

Insurance Adjustment: ($ 0.00)

Total Balance Due: $ 0.00

Payment Terms: Due upon receipt. Please make checks payable to "Specialist Neurology Associates".
Note: This assessment covers clinical evaluation and diagnostic interpretation. External laboratory or imaging fees are billed separately.