NEUROLOGY SPECIALIST GROUP

123 Medical Plaza, Suite 400
Healthcare City, ST 12345
Phone: (555) 010-9988

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
DOB: _____
ID: _____

BILLING DETAILS

Insurance: _____
Policy #: _____
Referring MD: _____

Date of Service	CPT Code / Description	Qty	Unit Cost	Amount
	Initial Neurological Consultation			
	EEG / EMG Diagnostic Testing			
	Nerve Conduction Study			
	Follow-up Examination			

Subtotal: $ _____
Insurance Paid: - $ _____
Copay Received: - $ _____

BALANCE DUE: $ _____

Payment Terms: Please remit payment within 30 days. Make checks payable to "Neurology Specialist Group".

Note: Diagnosis codes and detailed clinical notes are available upon request for insurance reconciliation.