

# PSYCHIATRIC CONSULTATION

[Provider Name, MD/NP]  
[License Number / NPI]  
[Address]  
[Phone Number]

## INVOICE

Invoice #: \_\_\_\_\_  
Date: \_\_\_\_\_

---

### PATIENT INFORMATION

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
ID/Insurance #: \_\_\_\_\_

Date of Service	CPT Code	Description of Service	Amount
		Initial Psychiatric Evaluation	\$
		Medication Management	\$
		Psychotherapy Add-on	\$

Subtotal: \$ \_\_\_\_\_  
Insurance Paid: (\$ \_\_\_\_\_)

---

**Total Balance Due: \$ \_\_\_\_\_**

### PAYMENT INFORMATION

Due Date: Upon Receipt  
Make checks payable to: \_\_\_\_\_  
Diagnosis Code (ICD-10): \_\_\_\_\_

This document contains confidential health information. If you are not the intended recipient, please notify the provider immediately.