[Clinic Name]

[Specialist Name, Credentials]
[Address Line 1]
[City, State, Zip]
[Phone Number] | [Email]

INVOICE

Invoice #: ___________
Date: ___________
NPI #: ___________

PATIENT INFORMATION

Name: ____________________
DOB: _____________________
Parent/Guardian: ____________

INSURANCE INFO

Carrier: ____________________
Policy #: ____________________
ICD-10 Code: ________________

Date of Service	CPT Code	Description of Services	Amount
		Developmental/Behavioral Evaluation	$
		Standardized Testing/Assessment	$
		Follow-up Consultation	$

Subtotal: $_______
Insurance Paid: $_______

Balance Due: $_______

Payment Instructions: Please make checks payable to [Clinic Name]. Payment is due within 30 days. For electronic transfers, use [Payment Reference].

Thank you for choosing us for your child's developmental care.