PSYCHIATRIC ASSESSMENT INVOICE

Adolescent Behavioral Health Services

INVOICE #

_____

DATE

_____

PROVIDER / FACILITY INFORMATION

PATIENT INFORMATION
Name: _____
DOB: _____ Age: _____

RESPONSIBLE PARTY / GUARANTOR (IF DIFFERENT FROM PATIENT)

Date of Service	CPT Code	Description of Assessment Services	Units	Rate	Amount
	90792	Psychiatric Diagnostic Evaluation w/ Medical Services			
		Psychological Testing / Adolescent Screening			
		Family Assessment / Consultation			

SUBTOTAL	$
INSURANCE PAID	$
TOTAL BALANCE DUE	**$**

DIAGNOSTIC CODES (ICD-10) / CLINICAL NOTES

Payment is due within 30 days. Please make checks payable to the provider listed above.

Confidential Medical Document