INVOICE

Provider Name/Clinic
NPI Number: _____
Address Line 1
City, State, Zip
Phone: (555) 000-0000

Invoice #: _____
Date: _____
Due Date: _____

PATIENT INFORMATION Name: _____
DOB: _____
ID #: _____
BILLING ADDRESS _____
_____
_____

Date of Service	CPT Code / Description	Diagnosis Code	Amount
_____	90791 - Psychiatric Diagnostic Evaluation	_____	$ _____
_____	90785 - Interactive Complexity (if applicable)	_____	$ _____
		Subtotal	$ _____
		Insurance Paid	($ _____)

Date of Service	CPT Code / Description	Diagnosis Code	Amount
		Total Patient Responsibility	**$ _____**

PAYMENT INSTRUCTIONS

Please make checks payable to: _____
For electronic payments: _____

Note: This diagnostic evaluation does not constitute a continuous treatment agreement unless otherwise specified. Confidentiality is maintained in accordance with HIPAA regulations.