CLINICAL PSYCHIATRY DIAGNOSTIC EVALUATION

[Clinic Name]
[Practitioner Name, Credentials]
[Street Address]
[City, State, Zip]
[NPI Number] | [Tax ID]

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

PATIENT INFORMATION:

Name: _____
DOB: _____
ID #: _____

BILLING TO:

[Recipient Name/Insurance]
[Address]
[Policy/Group Number]

Date of Service	CPT Code	Description of Service	Amount
_____	90791 / 90792	Psychiatric Diagnostic Evaluation	$ 0.00
_____		Psychological Testing / Assessment	$ 0.00
_____		Other: _____	$ 0.00

Subtotal: $ 0.00
Insurance Adjustment: ($ 0.00)
TOTAL DUE: $ 0.00

Notes / Diagnosis Codes (ICD-10):

_____

Please make checks payable to: [Clinic Name]

Confidential Medical Record: This document contains protected health information (PHI).