PSYCHIATRIC PRACTICE NAME

Address Line 1
City, State, Zip Code
Phone: (555) 000-0000
Tax ID / NPI: _____

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name:

DOB:

ID/Record #:

BILLING INFORMATION

Payer/Insurance:

Policy #:

Authorization #:

Service Date	CPT Code / Description	Duration	Rate	Total
	90792 Psychiatric Diagnostic Evaluation with Medical Services	60-90 min	$	$
	Initial Screening & Assessment Scales	-	$	$
	Administrative / Processing Fee	-	$	$

Subtotal: $_____
Insurance Adjustment: ($_____)

Amount Paid: $_____
BALANCE DUE: $_____

PAYMENT INSTRUCTIONS

Please make checks payable to **[Practice Name]** or pay via portal. Payment is due within 15 days of service.

Note: This document serves as a medical invoice. For insurance reimbursement purposes, please ensure all diagnostic codes (ICD-10) are verified with your provider. Confidentiality Notice: This document contains protected health information.