FORENSIC PSYCHIATRIC SERVICES
[Name/Medical Group]
[Street Address]
[City, State, Zip]
[Phone / License Number]

INVOICE
Date: _____
Invoice #: _____

BILL TO:
[Law Firm Name]
[Attorney Name]
[Street Address]
[City, State, Zip]

CASE REFERENCE:
Subject Name: _____
Case Number: _____
Jurisdiction: _____

Date	Description of Service	Rate/Hr	Hours	Total
	Record Review / Medical Legal Research	$		$
	Clinical Examination / Interview	$		$
	Psychological Testing / Interpretation	$		$
	Report Drafting & Preparation	$		$
	Expert Witness Testimony / Deposition	$		$
	Travel / Administrative Expenses	-	-	$

Subtotal: $_____
Retainer Applied: ($_____)
Balance Due: $_____

Payment Terms: Net [30] days. Please make checks payable to "[Payee Name]".

Tax ID / EIN: _____