INVOICE

Geriatric Psychiatric Evaluation Services

Invoice #: _____

Date: _____

PROVIDER INFORMATION

[Provider/Clinic Name]
[License/NPI Number]
[Address]
[Phone/Email]

PATIENT / RESPONSIBLE PARTY

[Patient Name]
[DOB/Patient ID]
[Billing Address]
[Insurance Policy ID]

Date of Service	CPT Code / Description	Units/Hours	Rate	Amount
	Initial Comprehensive Evaluation			
	Neurocognitive Screening			
	Medication Management Review			
	Family/Caregiver Consultation			

Subtotal: $ _____
Insurance Adjustment: ($ _____)
Balance Due: $ _____

Payment Terms: Due within 30 days of invoice date.

Notes: Please include the invoice number with your payment. For clinical inquiries or records requests, please contact the office directly.