INVOICE

Psychiatric Consultation Services

Invoice #: _____

Date: _____

PROVIDER:
[Clinic/Physician Name]
[NPI Number]
[Address Line 1]
[Phone / Email]
PATIENT:
[Patient Name]
[Date of Birth]
[Patient ID/Chart #]
[Address Line 1]

Date of Service	CPT Code	Description of Service	Fee

Subtotal: $0.00
Tax: $0.00

Total Due: $0.00

DIAGNOSIS CODES (ICD-10):
1. _____
2. _____
PAYMENT STATUS:
[ ] Paid in Full
[ ] Balance Outstanding

Notes: Please include the invoice number with your payment. Make checks payable to the provider listed above.