MEDICAL INVOICE

Provider: [Practice Name / Physician Name]
[NPI Number] | [Tax ID]
[Address Line 1]
[City, State, Zip]

Invoice #: [00000]
Date: [Date]
Due Date: [Date]

PATIENT INFORMATION

Name: [Child's Full Name]
DOB: [MM/DD/YYYY]
Guardian: [Parent/Guardian Name]

BILLING ADDRESS

[Street Address]
[City, State, Zip]
[Phone Number]

Service Date	CPT Code	Description of Service	Amount
[Date]	90791	Psychiatric Diagnostic Evaluation (Non-Medical)	$0.00
[Date]	90792	Psychiatric Diagnostic Evaluation w/ Medical Services	$0.00
[Date]	96110	Developmental Screening / Behavioral Assessment	$0.00

Service Date	CPT Code	Description of Service	Amount
[Date]	90834	Psychotherapy, 45 Minutes	$0.00

Subtotal: $0.00
Insurance Paid: ($0.00)
Balance Due: $0.00

Diagnosis Codes (ICD-10): [F-Codes Here]

Notes: Payments are due within 30 days. Please include the invoice number with your payment. Checks payable to [Practice Name].