INVOICE

Practice Name / Clinician Name
License No: [Number]
123 Medical Plaza, Suite 400
City, State, Zip

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

BILL TO:

[Patient Name]
[Address]
[City, State, Zip]
[Phone Number]

INSURANCE INFO (IF APPLICABLE):

Provider: [Insurance Co]
Member ID: [ID Number]
Auth Code: [Code]

DATE OF SERVICE	CPT CODE	DESCRIPTION OF ASSESSMENT SERVICES	RATE	AMOUNT
[Date]	[Code]	Psychiatric Diagnostic Evaluation	$0.00	$0.00
[Date]	[Code]	Psychological Testing & Scoring	$0.00	$0.00
[Date]	[Code]	Clinical Summary & Written Report	$0.00	$0.00

Subtotal:$0.00
Insurance Adjustment:($0.00)

TOTAL DUE:$0.00

PAYMENT INSTRUCTIONS:

Please make checks payable to [Practice Name].
For Electronic Funds Transfer (EFT): [Details]
Payment is requested within 15 days of invoice date.

NPI: [Number] | Tax ID: [Number]