[Practice Name]

[Clinician Name, Credentials]
[Address Line 1]
[City, State, Zip]
[Phone] | [NPI Number]

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION [Patient Full Name]
[Date of Birth]
[Patient Address]
[Insurance Member ID]
BILLING DETAILS Date of Service: _____
Place of Service: [11 - Office / 02 - Telehealth]
Diagnosis Code (ICD-10): _____

CPT Code	Description of Service	Duration	Rate	Total
90791	Psychiatric Diagnostic Evaluation	_____ min	$0.00	$0.00

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

Payment Instructions: Please remit payment within 30 days. Make checks payable to [Practice Name].

Confidential Health Information Enclosed. This document is intended only for the use of the individual or entity to which it is addressed.