# INVOICE

**Provider:** _____

NPI: _____ | Tax ID: _____

**INVOICE #** _____

**DATE:** _____

---

**PATIENT INFORMATION**

Name: _____

DOB: _____

ID/Policy #: _____

**PAYMENT STATUS**

[ ] Due on Receipt
[ ] Paid in Full
[ ] Insurance Pending

| Date of Service | CPT Code | Description of Service | Fee |
|---|---|---|---|
| _____ | 90792 | Psychiatric Diagnostic Evaluation w/ Med Services | $ _____ |
| _____ | 90833 | Psychotherapy (30 min) with E/M Service | $ _____ |
| _____ | _____ | Other: _____ | $ _____ |

Subtotal: $ _____

Insurance Adjustment: ($ _____)

Patient Responsibility: **$ _____**

**Diagnosis Codes (ICD-10):** _____

**Note:** This document serves as a clinical invoice for psychiatric services rendered. Please retain for your records or insurance reimbursement requests.

Office Address: _____