PSYCHIATRIC DIAGNOSTIC STATEMENT

[Practice Name]
[Address Line 1]
[NPI Number] | [Tax ID]

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____

DOB: _____

ID/Policy #: _____

Provider: _____

DIAGNOSTIC SUMMARY (ICD-10 / DSM-5)

Code	Description	Service Date	Fee
_____	Psychiatric Diagnostic Evaluation	_____	$ _____
_____	_____	_____	$ _____
_____	_____	_____	$ _____

Subtotal: $ _____
Paid/Insurance: $ _____
Balance Due: $ _____

CLINICIAN ATTESTATION

I certify that the above diagnostic services were rendered and are documented in the patient's clinical record.

Signature: _____ Date: _____

Confidential Medical Record - Protected Health Information (PHI).
Terms: Payment due within 30 days. Please make checks payable to [Practice Name].