[Psychiatrist Name / Clinic Name]

[Medical License Number]
[Street Address]
[City, State, Zip Code]
[Phone Number / Email]

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

PATIENT INFORMATION

Name: _____
Patient ID: _____
Address: _____
Insurance ID: _____

Date of Service	CPT Code / Description	Duration	Amount
[DD/MM/YYYY]	[e.g., 99214 - Psychiatric Evaluation]	[Minutes]	$0.00
[DD/MM/YYYY]	[e.g., 90833 - Psychotherapy Add-on]	[Minutes]	$0.00

Subtotal: $0.00
Insurance Adjustment: ($0.00)
Total Amount Due: $0.00

PAYMENT INSTRUCTIONS

Please make checks payable to **[Clinic Name]**.
For Electronic Funds Transfer: **[Routing/Account Info]**
Credit Card payments can be made via: **[Portal Link]**

Confidentiality Notice: This document contains protected health information (PHI) and is intended solely for the person named above. If you have received this in error, please notify the sender immediately.

Diagnosis Codes (ICD-10): _____