STATEMENT OF SERVICES

CLIENT NAME: _____❑ M ❑ F DATE OF BIRTH: _____

DATE OF SERVICE: _____ DIAGNOSTIC CODE (DSM):_____

SERVICES RENDERED
❑ Initial Evaluation (90791)
❑Psychotherapy: 90832/30" ❑90834 /45" ❑90837/60"
❑Family Psychotherapy w/patient (90847)
❑ Family Psychotherapy w/o patient (90846)
❑ Multi-Family Psychotherapy (90849)
❑ Group Psychotherapy (90853)
❑ Crisis Psychotherapy 90839/60" ❑+90840 each addl 30"
❑ No Show/Late Cancellation (less than 24 hours) ❑ Other_____ ❑Other_____

PRODUCTS
❑ _____
❑ _____
❑ _____
❑ _____

TOTAL CHARGE: _____ TOTAL PAYMENT: _____ AMOUNT DUE: _____
❑Cash ❑Check ❑Credit Card ❑PayPal

_____
Provider Signature Degree Title Date

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