RECEIPT NUMBER	DATE	PROFESSIONAL SERVICE	CHARGE	PAID	NEW BALANCE	PREVIOUS BALANCE	NAME

You **PAID** this amount → PAID

This is a **STATEMENT** of your account to date → NEW BALANCE

OFFICE - MEDICAL

	INITIAL	SUBSEQUENT	FEE
❑ Minimal		99402	______
❑ Brief		99213	______
❑ Intermediate		99214	______
❑ Comprehensive	99205	99215	______
❑ Uncancelled Appointment	90001		

OTHER SERVICES - MEDICAL

❑ Collect / Handle Specimen	99000	______
❑ Educational Supplies	99071	______
❑ Supplies	99070	______

OFFICE - MEDICAL PSYCHOTHERAPY

❑ Initial Diagnosis Interview	90801	______
❑ Individual - 20-30 Minutes	90804	______
❑ Individual - 60-60 Minutes	90806	______
❑ Individual - Unspecified	90841	______
❑ Pharmacological Management	90862	______

OTHER SERVICES - PSYCHIATRIC

❑ Narcosynthesis for Diagnosis or Treatment / Sodium Amytal	90835	______
❑ Electroconvulsive Therapy-1 Stimulus	90870	______
❑ Electroconvulsive Therapy-2 Stimuli	90871	______
❑ Environmental Intervention	90882	______
❑ Eval Hosp. Records / Tests, Etc.	90825	______
❑ Telephone Consultation	90831	______
❑ Interpretation of Procedures	90887	______
❑ Prep of Report for Physicians / Ins.	90889	______
❑ Unlisted Psychiatric Procedure	90899	______

CONSULTATION

	INITIAL	SUBSEQUENT	FEE
❑ Brief	90800	90840	______
❑ Limited	90805	90805	______
❑ Intermediate	90810	90842	______
❑ Extensive	90820	90843	______
❑ Comprehensive	90830		
❑ Complex			
❑ Extensive Second Opinion		90852	______
❑ Comprehensive Second Opinion		90853	______

CONSULTATION

❑ Phone Consult 15 Minute	99442	______
❑ Phone Consult 30 Minute	99443	______
❑ After Office Hours	99050	______
❑ ______________________	______	______
❑ ______________________	______	______
❑ ______________________	______	______

DIAGNOSIS: ______________________________

NPI # 1414520290

Date of Service:______________________

Chart No.______________________

Patient:______________________

Address:______________________

City______________State____Zip________

Policyholder or Responsible Party:

____

Relationship to Insured: Birthdate:

____

Employer:

____

Insurance Name: Group #

____

Insured ID / Medicare Number

____

Other Health Insurance Coverage:

____

Date Symptoms Appeared: __________

Conditions related to:

Employment: ❑ Yes ❑ No Accident: ❑ Yes ❑ No

Special Instructions:

____

____

____

____

Doctor's Signature

INSURANCE CARRIERS: This form has been adopted to keep paperwork down. If any additional form or itemized bill is required, it will be completed upon receipt of $25.00

PSYCHIATRY INSTITUTE

JOHN A. JONES, M.D.

22 N. Central Avenue, Suite 55

Tempe, Arizona 85012

Tel: (602) 435-26546

IRS No. 55-0648097

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician named in this form to release any information acquired during this examination or treatment. ASSIGNMENT OF BENEFITS: I certify that the services listed have been received and I authorize payment be made to myself and the provider named.

PATIENT SIGNATURE: ______________________ DATE: ______________