



Patient Receipt

→ Appointment Date: _____

Provider Information:

Smith Family MD

Dr. Scott Smith

Provider License: 16211

Billing NPI: 1669027595

Provider NPI: 1972550283

Provider EIN: 84-2626186

Place of Service Code: 11

990 Lake Hunter Circle

Mount Pleasant, SC 29466

Office Phone: (843) 972-8136

Office Fax: 843-353-1983

Email:

Help@SmithFamilyMD.com

Patient Information:

→ Patient Name: _____ → Patient Address: _____

→ Date of Birth: _____ → Patient Phone: _____

Treatment:

Date of Service	Billing Code	ICD10 Code	Qty	Fee	Dis	Total
	99214: Treatment for resistant depression	F33.2	1.00	\$250.00	\$0.00	\$250.00

Total Charges: \$250.00

Total Discounts: \$0.00

Patient Paid: \$250.00

Insurance Paid: \$0.00

Patient Balance Due: \$0.00

Insurance Balance Due: \$0.00

I authorize the release of any medical information necessary to process this claim.

→ Date: _____

Patient Signature: _____

Provider Signature: Scott Smith MD