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: ______________________________
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Date of Birth: ______________________________

Patient Phone: ______________________________

Treatment:

Date of Service	Billing Code	ICD10 Code	Qty	Fee	Dis	Total
	99214-Modifier 95: 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 ______________________________