INVOICE

PROVIDER [Provider Name / Clinic Name]
[Address Line 1]
[NPI Number / Tax ID]

INVOICE # [0000]
DATE [MM/DD/YYYY]

BILL TO [Client Full Name]
[Client Address]
[Insurance Policy ID, if applicable]

PATIENT INFORMATION DOB: [MM/DD/YYYY]
Diagnosis Code (ICD-10): [Code]

DATE OF SERVICE	CPT CODE	DESCRIPTION OF SERVICE	DURATION	RATE	AMOUNT
[Date]	[90837]	Psychotherapy, 60 min	[60 min]	$0.00	$0.00
[Date]	[Code]	[Service Name]	[Units]	$0.00	$0.00

Subtotal: $0.00

Insurance Paid/Adjusted: ($0.00)

Client Responsibility: $0.00

Total Balance Due: $0.00

NOTES / PAYMENT INSTRUCTIONS

Please make checks payable to [Provider Name]. For credit card payments, please use the portal or call the office. Payment is due within 30 days of receipt.

Thank you for your commitment to your mental health and wellness.