CLINIC INVOICE

[Practice Name]
[Clinician Name, Credentials]
[License Number]
[Address, City, Zip]
[Phone / Email]

INVOICE NO: [000]
DATE: [Date]

BILL TO:

[Parent/Guardian Name]
[Address]
[City, State, Zip]

PATIENT INFORMATION:

[Child's Full Name]
[Date of Birth]
[Diagnosis Code/ICD-10]

Date of Service	CPT Code / Service Description	Duration	Rate	Amount
[Date]	[Code] - [e.g., Psychotherapy, 45 min]	[Mins]	$0.00	$0.00
[Date]	[Code] - [e.g., Parent Consultation]	[Mins]	$0.00	$0.00

Subtotal: $0.00

Insurance Paid: ($0.00)

Total Balance Due: $0.00

NOTES / CLINICAL OBSERVATIONS:

Payment Terms: Please make checks payable to [Practice Name]. Payment is due within 15 days.

Notice of Privacy: This document may contain confidential health information protected by HIPAA. Please handle accordingly.