[Psychologist Name/Practice]

[License Number]
[Street Address]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____

BILL TO

[Client Name]
[Client Address]
[Phone/Email]

INSURANCE INFORMATION (IF APPLICABLE)

Provider: _____
Policy ID: _____
Group #: _____

Date of Service	CPT Code	Description of Service	Fee

Subtotal: $0.00
Insurance Paid: $0.00

Amount Due: $0.00

PAYMENT INSTRUCTIONS

Please make checks payable to **[Practice Name]** or pay via [Payment Portal Link/Method]. Payment is due within [Number] days of the invoice date.

Confidential Health Information: This document may contain protected health information (PHI) and is intended solely for the use of the individual named above.