INVOICE

Mental Health Services

Invoice #: _____

Date: _____

Provider:

_____

_____

License #: _____

NPI: _____

Bill To:

_____

_____

ID/Policy #: _____

Date of Service	CPT Code	Description of CBT Services	Fee
_____	_____	Individual Psychotherapy - CBT	$ _____
_____	_____	_____	$ _____

Subtotal: $ _____

Insurance Paid: $ _____

Balance Due: $ _____

Payment Instructions: Please make checks payable to the provider listed above or pay via electronic portal. Payment is due within 30 days.

Confidentiality Note: This document contains protected health information. Please handle accordingly under HIPAA guidelines.