INVOICE

Provider:

License #:

Tax ID/EIN:

Invoice #:

Date:

Client Names (Couple):
Billing Address:

Date of Service	CPT Code / Description	Duration	Rate	Amount
	90847 - Family/Couples Therapy		$	$
			$	$

Subtotal: $

Payments/Credits: ($)

Total Balance Due: $

Payment Terms:

Diagnosis Codes (ICD-10):

Thank you for your commitment to the therapeutic process.