# INVOICE

**[Therapist or Practice Name]**
[Street Address]
[City, State, Zip]
[Phone Number]
[Tax ID/NPI Number]

**Bill To:**
[Responsible Party Name]
[Family Name/Case Ref]
[Address]

**Invoice #:** [0000]
**Date:** [Date]
**Due Date:** [Date]

| Date of Service | Service Description (CPT Code) | Duration | Rate | Amount |
|---|---|---|---|---|
| [Date] | Family Psychotherapy (90847) | [60 min] | $0.00 | $0.00 |
| [Date] | Family Psychotherapy (90847) | [60 min] | $0.00 | $0.00 |

**Total Due: $0.00**

**Payment Instructions:**
Please make checks payable to [Practice Name] or pay via [Online Portal/App].

**Notes:**
[Additional notes regarding insurance reimbursement or late cancellation policies.]