PSYCHOTHERAPY INVOICE

[Provider Name/Practice Name]
[License Number]
[Address Line 1]
[City, State, Zip]
[Phone Number]

Invoice #: [000]
Date: [MM/DD/YYYY]

BILL TO

[Client Name]
[Client Address]
[City, State, Zip]

Date of Service	Service Code (CPT)	Description	Fee
[Date]	[90834/90837]	Individual Psychotherapy, [45/60] min	$0.00

Subtotal: $0.00

Paid to Date: ($0.00)

Balance Due: $0.00

PAYMENT INSTRUCTIONS

[e.g., Please make checks payable to Practice Name or pay via Client Portal.]