[LCSW Name/Practice Name]

[Street Address]
[City, State, Zip]
[Phone Number]
[Email Address]
NPI: [Provider NPI Number]
Tax ID: [Tax ID/EIN]

INVOICE

Invoice #: [0000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

BILL TO

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

DIAGNOSIS & CODES

ICD-10 Code: [Code]
Diagnosis: [Description]

Date of Service	CPT Code	Description of Service	Fee
[MM/DD/YYYY]	[e.g., 90837]	Psychotherapy, 60 minutes	$[0.00]
[MM/DD/YYYY]	[e.g., 90834]	Psychotherapy, 45 minutes	$[0.00]

Subtotal: $[0.00]

Paid by Insurance: - $[0.00]

Balance Due: $[0.00]

Payment Instructions: Please make checks payable to [Practice Name] or pay via [Payment Portal/Zelle/Venmo].

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