MEDICAL INVOICE

Psychotherapy Services

Invoice #: _____

Date: _____

Provider Information:

Name: _____

NPI #: _____

Tax ID/EIN: _____

Address: _____

Phone: _____

Patient Information:

Name: _____

DOB: _____

ID/Policy #: _____

Address: _____

Date of Service	CPT Code	Diagnosis (ICD-10)	Description	Fee

Total Charge: $_____

Insurance Paid: $_____

Patient Responsibility: $_____

Amount Due: $_____

Notes/Clinical Comments:

This is a confidential medical document. Please make checks payable to the provider listed above.