**[Counselor Name/Practice Name]**
[Address Line 1]
[City, State, Zip]
[Phone Number]
[Tax ID / NPI Number]

# INVOICE

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

**Bill To:**
[Client Name]
[Client Address]
[City, State, Zip]

| Date of Service | Service Description (CPT Code) | Duration | Rate | Amount |
|---|---|---|---|---|
| [Date] | Psychotherapy, [Code] | [X] mins | $0.00 | $0.00 |
| [Date] | Psychotherapy, [Code] | [X] mins | $0.00 | $0.00 |

Subtotal: $0.00
Insurance Paid: ($0.00)
Balance Due: $0.00

**Payment Terms:** Payment is due within [X] days of invoice date.
**Notes:** [Diagnostic Codes (ICD-10) or session notes if required for reimbursement].