# INVOICE

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

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

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**BILL TO:**

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

**INSURANCE INFO (IF APPLICABLE):**

Provider: [Insurance Co Name]
Member ID: [ID Number]
Authorization: [Auth Number]

| Date of Service | CPT Code | Description of Service | Duration | Rate | Amount |
|---|---|---|---|---|---|
| [MM/DD/YY] | [90837] | Psychotherapy, 60 min | 60 min | $0.00 | $0.00 |
| [MM/DD/YY] | [90834] | Psychotherapy, 45 min | 45 min | $0.00 | $0.00 |

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

**NOTES & PAYMENT INSTRUCTIONS**

Please make checks payable to **[Practice Name]**. For electronic payments via [Zelle/Venmo/Portal], use account **[Account Detail]**. Thank you for your payment.

*Confidentiality Notice: This document contains private health information intended only for the recipient.*