[Practice Name]

[Provider Name, Credentials]
[Address Line 1]
[City, State, Zip]
[Phone Number] | [NPI Number]

INVOICE

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

BILL TO

[Client Name]
[Client Address]
[City, State, Zip]
[Client ID/DOB]

INSURANCE INFORMATION

Provider: [Payer Name]
Policy #: [Member ID]
Group #: [Group ID]
Auth #: [Prior Auth ID]

Date of Service	CPT Code	Description	Units	Rate	Total
[MM/DD/YY]	[90834]	Psychotherapy, 45 mins	1	$0.00	$0.00
[MM/DD/YY]	[90837]	Psychotherapy, 60 mins	1	$0.00	$0.00

Subtotal: $0.00
Insurance Paid: ($0.00)

Patient Balance: $0.00

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

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