Psychotherapy Services

[Provider Name, Credentials]
[NPI Number / License Number]
[Business Address]
[Phone / Email]

INVOICE

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

BILL TO

[Client Name]
[Client Address]
[Client Phone]

SESSION DETAILS

Platform: [Telehealth Platform Name]
Time: [00:00 AM/PM]

Date of Service	CPT Code / Description	Rate	Amount
[MM/DD/YYYY]	90837 - Psychotherapy, 60 minutes via Telehealth (Place of Service 02)	$0.00	$0.00

Subtotal: $0.00
Paid: $0.00
Balance Due: $0.00

Notes: This invoice serves as a receipt for telehealth psychotherapy services. Please retain for your records or insurance reimbursement requests.

Payment Method: [Credit Card / Bank Transfer / Other]