PSYCHIATRIC CLINIC

123 Medical Plaza, Suite 100
City, State, Zip Code
Phone: (555) 012-3456

INVOICE

Invoice #: ___________
Date: ___________

PATIENT BILLING:

Name: ______________________
ID: _________________________
Address: ____________________

PRACTITIONER:

Name: ______________________
NPI: ________________________
License: _____________________

Date of Service	CPT Code / Service Description	Duration	Amount

Subtotal: $___________

Insurance Paid: $___________

Total Balance Due: $___________

Notes: ____

Payment is due within 30 days. Please make checks payable to the clinic name above.

Thank you for choosing our practice.