[Clinic Name]

[Clinician Name, Credentials]
[Address Line 1]
[Phone Number]
[Tax ID / NPI Number]

INVOICE

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

BILL TO:

[Parent/Guardian Name]
[Address Line 1]
[City, State, Zip]

PATIENT INFORMATION:

Patient: [Child's Name]
DOB: [MM/DD/YYYY]
ICD-10 Code: [Code]

Date	CPT Code	Description of Service	Fee
[Date]	[Code]	[e.g., Speech Therapy Session - 45 min]	$0.00
[Date]	[Code]	[e.g., Comprehensive Evaluation]	$0.00

Date	CPT Code	Description of Service	Fee

Subtotal: $0.00
Paid/Insurance: ($0.00)
Total Due: $0.00

Payment Terms: Please remit payment within [Number] days. Checks payable to [Clinic Name].

This document serves as an official statement for insurance reimbursement purposes.