INVOICE

[Provider Name/Practice Name]
[NPI Number]
[Address Line 1]
[City, State, Zip]
[Phone / Email]

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

PATIENT INFORMATION

[Patient Full Name]
[Date of Birth]
[Patient ID/Reference]

INSURANCE DETAILS (IF APPLICABLE)

[Insurance Carrier]
[Policy Number]
[Auth Number]

Date of Service	CPT Code	Description (Telehealth)	Rate	Amount
[Date]	[90834]	Psychotherapy, 45 min (Place of Service: 02)	$0.00	$0.00
[Date]	[90837]	Psychotherapy, 60 min (Place of Service: 02)	$0.00	$0.00

Subtotal: $0.00
Insurance Paid: ($0.00)

Balance Due: $0.00

Payment Instructions: [Credit Card / Patient Portal / Check]

Diagnosis Codes (ICD-10): [FXX.XX]

Thank you for choosing [Practice Name] for your behavioral health needs.