INVOICE

Invoice #: [0000]
Date: [Date]

[Provider/Practice Name]
[Tax ID / NPI Number]
[Street Address]
[City, State, Zip]
[Phone/Email]

CLIENT INFORMATION [Client Full Name]
[Client Address]
[City, State, Zip]
[Insurance ID - Optional]

PAYMENT STATUS

[Balance Due / Paid]

Date of Service	Service Code / Description	Duration	Rate	Amount
[MM/DD/YYYY]	90834 - Psychotherapy (Telehealth)	[45/60] min	$[0.00]	$[0.00]

Subtotal: $[0.00]

Insurance Adjustment: -$[0.00]

Total Amount Due: $[0.00]

Notes: [e.g., Payment due within 15 days. Platform used: HIPAA-compliant Zoom/Doxy.me]

Diagnosis Codes (ICD-10): [Code]

Thank you for your commitment to your mental wellness.