TELEHEALTH INVOICE

[Clinic Name]
[Clinic Address]
[Phone Number]
[Tax ID/NPI]

Invoice #: _____
Date: _____
Due Date: _____

PATIENT INFORMATION

Name: _____
ID: _____
Address: _____

APPOINTMENT DETAILS

Provider: _____
Service Date: _____
Platform: [Secure Video/Phone]

Service Code (CPT)	Description	Quantity	Unit Price	Total
_____	Telehealth Consultation	_____	$ _____	$ _____
_____	_____	_____	$ _____	$ _____

Subtotal: $ _____

Insurance Adjustment: ($ _____)

Patient Co-pay: $ _____

Balance Due: $ _____

Payment is required within [X] days of receipt. Please contact the billing office for insurance inquiries.

Thank you for choosing our virtual care services.