Psychology Telemedicine Service

[Provider Name / Practice Name]
[NPI Number / Professional License]
[Contact Email / Phone]

INVOICE

Invoice #: [0000]
Date: [MM/DD/YYYY]

PATIENT INFORMATION

[Patient Full Name]
[Address/City/State]
[Patient ID/DOB]

PLATFORM / METHOD

Secure Video Session
[Insurance Provider Name]
[Policy Number]

Date of Service	CPT Code / Description	Duration	Rate	Amount
[MM/DD/YYYY]	[90834] - Psychotherapy, 45 min	45 min	$[0.00]	$[0.00]
[MM/DD/YYYY]	[90837] - Psychotherapy, 60 min	60 min	$[0.00]	$[0.00]

Subtotal: $[0.00]

Insurance Applied: - $[0.00]

Total Due: $[0.00]

Payment Instructions: Please remit payment via [Platform/Portal Name] or via bank transfer to [Account Details].

Confidentiality Notice: This document contains protected health information (PHI) and is intended solely for the recipient named above.