# INVOICE

Telehealth Services

**Invoice #:** _____
**Date:** _____

**PROVIDER DETAILS**

_____

_____

NPI: _____

**PATIENT INFORMATION**

_____

_____

DOB: _____

| Description (Service Code) | Date of Service | Amount |
|---|---|---|
| Telehealth Consultation (CPT: _____) | _____ | $ _____ |
| Other: _____ | _____ | $ _____ |

Subtotal: $ _____
Insurance Paid: - $ _____
Balance Due: $ _____

Payment is due within ____ days. Please use the invoice number as a reference for electronic transfers.

Thank you for choosing our digital health services.