INVOICE

[Provider/Clinic Name]
[NPI Number / Tax ID]
[Address Line 1]
[City, State, Zip]

Invoice #: _____
Date: _____
Due Date: _____

BILL TO:

[Patient Name]
[Patient Address]
[Patient Phone / Email]

PAYMENT DETAILS:

Method: [Credit Card/Insurance/Bank]
Status: [Pending/Paid]

Service Date	Description (CPT Code)	Duration	Rate	Amount
	Telehealth Consultation (Code: _____)			
	Follow-up / Administrative Fee			

Subtotal: $_____

Insurance Coverage: - $_____

Total Amount Due: $_____

Notes: Services provided via secure HIPAA-compliant video platform.

For billing inquiries, please contact [Email/Phone]. Thank you for choosing our telehealth services.