[Practice Name / Clinician Name]
[Professional Credentials/Qualifications]
[Office Address Line 1]
[City, State, Zip Code]
[Phone Number] | [NPI Number]

INVOICE

Date: *[DD/MM/YYYY]*
Invoice #: *[00000]*

PATIENT DETAILS

[Patient Full Name]
DOB: [DD/MM/YYYY]
ID/Record #: [Reference Number]

BILLING RECIPIENT

[Name/Insurance Provider]
[Billing Address]
[Contact Email/Phone]

Date of Service	CPT/HCPCS Code	Description of Clinical Service	Duration	Fee
[Date]	[90791/90792]	Psychiatric Diagnostic Evaluation	[Minutes]	$[0.00]
[Date]	[Code]	[Additional Assessment/Testing]	[Minutes]	$[0.00]

Subtotal:	$[0.00]
Tax/Other:	$[0.00]
Total Due:	**$[0.00]**

PAYMENT INSTRUCTIONS

Please make checks payable to **[Clinic Name]**.
For Bank Transfer: [Bank Name] | Routing: [Number] | Account: [Number]
Terms: Due upon receipt.

Confidential Clinical Document: This invoice may contain protected health information (PHI) and is intended solely for the recipient named above.