

# INVOICE

**[Provider/Clinic Name]**

[Street Address]

[City, State, Zip]

[Tax ID / NPI Number]

**Invoice #:** [0000]

**Date:** [MM/DD/YYYY]

**Due Date:** [MM/DD/YYYY]

**Bill To:**

[Client Name]

[Client Address]

[Phone Number]

**Session Details:**

**Modality:** [e.g., HRV, EEG, EMG]

**Duration:** [X] Minutes

**Location:** [Office/Telehealth]

Service Date	CPT Code	Description	Rate	Amount
[MM/DD/YY]	[90901]	Biofeedback Training/Session	\$0.00	\$0.00
[MM/DD/YY]	[90834]	Psychotherapy (if applicable)	\$0.00	\$0.00

Subtotal: \$0.00

Insurance Paid: (\$0.00)

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**Balance Due: \$0.00**

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**Notes:** [Payment terms, late fee policy, or clinical notes]

Thank you for your business.