INVOICE

Invoice #: Date:

Practice Name
Provider Name, Credentials Address Line 1 Phone / Email NPI / Tax ID

Client Information: Patient Name Address Date of Birth
Payment Status: Due Date Method of Payment

Date of Service	CPT Code / Description	Duration	Rate	Amount

Subtotal:

Insurance Paid:

Total Balance Due:

Diagnosis Codes (ICD-10):

Notes: Professional services rendered in confidential psychotherapy session. Please make checks payable to the provider listed above.