INVOICE

Telehealth Services

Invoice #: _____

Date: _____

PROVIDER INFORMATION

Practice Name: _____

Provider Name: _____

NPI Number: _____

Address: _____

Contact: _____

PATIENT INFORMATION

Name: _____

Date of Birth: _____

Patient ID: _____

Address: _____

Service Date	CPT/HCPCS Code	Description of Services	Qty	Unit Price	Total

Service Date	CPT/HCPCS Code	Description of Services	Qty	Unit Price	Total

Subtotal: $_____
Insurance Paid: ($_____)

Balance Due: $_____

Payment Instructions: _____

Notes: Consultation conducted via HIPAA-compliant video platform.

Thank you for choosing our telehealth services.