

# INVOICE

PROTECTED HEALTH INFORMATION (PHI)

[Provider Name/Practice]  
[Address]  
[NPI Number / Tax ID]  
[Phone Number]

## PATIENT INFORMATION

Name: [Patient Name]  
DOB: [MM/DD/YYYY]  
ID: [Patient Account #]  
Address: [Street, City, State, ZIP]

## INVOICE DETAILS

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

Date of Service	CPT/HCPCS Code	Description of Service	Unit Cost	Amount
[Date]	[Code]	[Description]	\$0.00	\$0.00
[Date]	[Code]	[Description]	\$0.00	\$0.00

**Subtotal:** \$0.00

Insurance Paid: (\$0.00)

Patient Responsibility: (\$0.00)

**Total Balance Due:** \$0.00

Payment Instructions: [Check/Credit Card/Portal Details]

***HIPAA PRIVACY NOTICE:*** *This document contains Protected Health Information (PHI) subject to protection under Federal Law (HIPAA). If you are not the intended recipient, please notify the sender and destroy this document immediately.*