INVOICE

[Provider Name/Practice Name]
[NPI Number]
[Tax ID / EIN]
[Street Address]
[City, State, Zip]

Invoice #: [000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

Bill To:
[Client Name]
[Client Address]
[City, State, Zip]

Insurance Info (if applicable):
ID: [Member ID]
Group: [Group Number]

Date of Service	CPT Code	Description	Amount
[MM/DD/YYYY]	[90837]	Psychotherapy, 60 minutes	$0.00
[MM/DD/YYYY]	[90791]	Psychiatric Diagnostic Evaluation	$0.00

Subtotal: $0.00
Insurance Paid/Adjustment: ($0.00)
Balance Due: $0.00

Notes / Payment Instructions:
Please make checks payable to [Provider Name] or pay via [Payment Portal Link]. Thank you for your commitment to your mental wellness.