INVOICE

[Your Business Name]
[Street address]
[City, State ZIP]
[email@yourbusiness.com]
[(555) 555-0123]

BILL TO

[Client Name]
[Street address]
[City, State ZIP]
[client@email.com]
Client: [Name, date of birth]

Invoice number:	TH-2026-10
Invoice date:	10/27/2026
Due date:	10/27/2026
Terms:	Due on receipt
Provider NPI:	[10-digit NPI]
Diagnosis:	[ICD-10 code]

SERVICE	UNIT PRICE	QUANTITY	AMOUNT
Psychotherapy, 53+ min CPT 90837 · [date]	$160.00	1	**$160.00**
Psychotherapy, 53+ min CPT 90837 · [date]	$160.00	1	**$160.00**
Psychotherapy, 53+ min CPT 90837 · [date]	$160.00	1	**$160.00**
Late cancellation [date], under 24 hours' notice	$80.00	1	**$80.00**

NOTES/MEMO

Sessions for [month]. You may submit this statement to your insurer for out-of-network reimbursement. Billing questions: [phone].

Subtotal:	$560.00
Amount due:	**$560.00**