ESTIMATE INVOICE

Post-Rehabilitation Exercise Services

Estimate #: _____

Date: _____

PROVIDER INFORMATION

Name/Clinic: _____

Address: _____

Phone: _____

CLIENT INFORMATION

Client Name: _____

ID/Case #: _____

Referring Provider: _____

Description of Exercise Service	Sessions/Qty	Rate	Amount
Initial Functional Assessment	____	$____	$____
Guided Post-Rehab Exercise Session	____	$____	$____
Program Design & Documentation	____	$____	$____
Specialized Equipment Usage	____	$____	$____

Subtotal: $_____
Tax/Fees: $_____
Estimated Total: $_____

Terms & Conditions:

- This is an estimate only, not a final bill.
- Estimate is valid for 30 days from the date issued.
- Actual costs may vary based on clinical progression and session frequency.
- Cancellations require 24-hour notice to avoid rescheduling fees.