# GERIATRIC PHYSICAL THERAPY

[Provider Name / Clinic]
[License Number]
[Phone Number]
[Email Address]

# INVOICE

Invoice #: _____
Date: _____

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**PATIENT BILLING**

[Patient Name]
[Street Address]
[City, State, Zip]
[Phone]

**CARE DETAILS**

Referring Physician: _____
ICD-10 Code(s): _____
Due Date: _____

| Date | Service / CPT Code Description | Hourly Rate | Hours | Amount |
|---|---|---|---|---|
| | Initial Evaluation (Geriatric Assessment) | $ | | $ |
| | Therapeutic Exercise (Mobility/Balance) | $ | | $ |

| Date | Service / CPT Code Description | Hourly Rate | Hours | Amount |
|---|---|---|---|---|
| | Gait Training / Fall Prevention | $ | | $ |
| | Manual Therapy / Neuromuscular Ed. | $ | | $ |

Subtotal: $ _____
Insurance Adjustment: ($ _____)
Balance Due: $ _____

**Notes:** Please make checks payable to [Provider Name]. Payments are due within [X] days of invoice date.

*Thank you for choosing us for your rehabilitative care and mobility needs.*