INVOICE

[Therapist/Agency Name]
[License #] / [NPI #]
[Address]
[Phone / Email]

Date: _____
Invoice #: _____

BILL TO:
[Patient Name]
[Patient Address]
[Payer/Insurance ID]

SERVICE PERIOD:
[Start Date] to [End Date]

Date of Service	CPT Code	Description of Service	Units/Hrs	Rate	Amount
		PT Evaluation (Home)			
		Therapeutic Exercise			
		Neuromuscular Re-ed			
		Gait Training			
		Manual Therapy			

Total Due: $ _____

Notes / Diagnosis Codes: _____

Payment Terms: Please make checks payable to [Name]. Due within [X] days.