

INVOICE

Practice Name

Address Line 1

City, State, Zip

Phone: (555) 000-0000

Invoice #: _____

Date: _____

Due Date: _____

BILL TO:

Patient Name

Address Line 1

City, State, Zip

Insurance ID (if applicable): _____

PROVIDER INFO:

Therapist: _____

NPI Number: _____

Tax ID / EIN: _____

Date of Service	Description / CPT Code	Hours/Units	Hourly Rate	Amount

Subtotal: \$ _____

Adjustments/Insurance: \$ _____

TOTAL BALANCE DUE: \$ _____

Notes / Payment Instructions:

Please make checks payable to: _____

Thank you for choosing our physical therapy services for your rehabilitation needs.