

INVOICE

Practice Name

Street Address

City, State, Zip

Phone / Email

Invoice #: _____

Date: _____

Due Date: _____

BILL TO:

Patient Name

Address

City, State, Zip

INSURANCE INFO:

Provider: _____

Policy #: _____

Auth #: _____

Date of Service	CPT Code	Description of Therapy Service	Units/Mins	Rate	Total

Subtotal: \$0.00

Insurance Paid: (\$0.00)

Balance Due: \$0.00

NPI Number: _____

Notes/Instructions: Please make checks payable to _____. Payments are due within 30 days of the invoice date.

Thank you for choosing our therapy services.