INVOICE

Clinic Name:
Address:
Phone:

Invoice #:
Date:

PATIENT INFORMATION

Name:
ID/Ref:
Diagnosis:

PROVIDER INFORMATION

Therapist:
License #:
NPI:

Date	CPT Code / Service Description	Hours/Units	Rate	Total

Subtotal:
Tax/Adj:
Balance Due:

Payment Terms: Due upon receipt. Please make checks payable to the clinic name above.

Thank you for choosing our rehabilitation services.