[Clinic Name]

[Address Line 1]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
ID/DOB: _____
Address: _____

INSURANCE / PROVIDER

Provider Name: _____
NPI Number: _____
Insurance ID: _____

Date of Service	CPT Code	Description of Therapy Session	Units	Rate	Total

Subtotal: $_____
Insurance Adjustment: ($_____)
Patient Co-pay: $_____

Amount Due: $_____

CLINICAL NOTES / RECOMMENDATIONS

Thank you for choosing [Clinic Name] for your rehabilitation needs.
Please make checks payable to **[Clinic Name]**. Payment is due within 30 days.