[Clinic Name]

[Street Address]
[City, State, Zip]
[Phone Number]
[NPI Number]

INVOICE

Invoice #: [0000]
Date: [MM/DD/YYYY]

PATIENT INFORMATION

[Patient Name]
[Patient Address]
[Phone Number]
DOB: [MM/DD/YYYY]

INSURANCE / REFERENCE

Provider: [Insurance Co Name]
ID: [Policy Number]
Auth #: [Authorization Number]

Date	CPT Code / Description	Units	Rate	Amount
[Date]	97110 - Therapeutic Exercise	[0]	$[0.00]	$[0.00]
[Date]	97140 - Manual Therapy	[0]	$[0.00]	$[0.00]
[Date]	97112 - Neuromuscular Re-ed	[0]	$[0.00]	$[0.00]

Subtotal: $[0.00]
Insurance Paid: ($[0.00])
Patient Co-pay: $[0.00]

Total Balance Due: $[0.00]

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

Notes: [Optional clinician notes or ICD-10 codes]