[Clinic Name]

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

INVOICE

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

BILL TO:

[Patient Name]
[Patient Address]
[Phone Number]
ID: [Patient ID/Policy #]

INSURANCE INFO:

[Carrier Name]
Group #: [Group ID]
Auth #: [Prior Auth #]

Date of Service	CPT Code	Description of Service	Units	Rate	Amount
[Date]	97161	PT Evaluation: Low Complexity	1	$0.00	$0.00
[Date]	97110	Therapeutic Exercise	[Unit]	$0.00	$0.00
[Date]	97140	Manual Therapy	[Unit]	$0.00	$0.00

Subtotal: $0.00

Insurance Adjustment: ($0.00)

Patient Co-pay/Paid: ($0.00)

Total Balance Due: $0.00

Diagnosis Codes (ICD-10): [Code 1], [Code 2]

Please make checks payable to: **[Clinic Name]**

Payment is due within [30] days of invoice date. Thank you for choosing our practice for your rehabilitation needs.