

# [CLINIC NAME]

Sports Medicine & Physical Therapy  
[Street Address]  
[City, State, Zip]  
[Phone Number]

## INVOICE

# [00000]  
Date: [MM/DD/YYYY]

### PATIENT INFORMATION

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

### BILLING / INSURANCE

Provider: [Insurance Name]  
Policy #: [ID Number]  
Referring Physician: [Doctor Name]

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)  
Total Balance Due: \$0.00

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**Diagnosis/Notes:** [ICD-10 Code] - [Description of Injury]

Payment Terms: Due upon receipt. Please make checks payable to [Clinic Name].