INVOICE

[Clinic Name]
[Address Line 1]
[City, State, Zip]

Invoice #: [00000]
Date: [MM/DD/YYYY]
Subscription Period: [Month, Year]

Bill To:

[Patient Name]
[Patient Address]
[Phone Number]

Provider Info:

PT License: [Number]
NPI: [Number]

Description	Sessions	Rate	Total
Physical Therapy Subscription Plan: [Plan Name]	[Qty]	$[0.00]	$[0.00]
Additional Add-on: [Item Name]	[Qty]	$[0.00]	$[0.00]

Subtotal: $[0.00]
Tax: $[0.00]
Grand Total: $[0.00]

Payment Status: [Paid / Pending]

Notes: Please retain this invoice for your records or insurance reimbursement claims (Superbill available upon request).