PEDIATRIC OCCUPATIONAL THERAPY

[Practice Name]
[Address Line 1]
[Phone Number]
[NPI Number / License #]

INVOICE

Invoice #: [000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

BILL TO (PARENT/GUARDIAN)

[Guardian Name]
[Address Line 1]
[City, State, Zip]
[Email]

PATIENT INFORMATION

Child Name: [Name]
Date of Birth: [MM/DD/YYYY]
Diagnosis Code: [ICD-10 Code]

Date	CPT Code	Description of Service	Duration	Rate	Amount
[Date]	[97530]	Therapeutic Activity	[60 min]	$0.00	$0.00
[Date]	[97110]	Therapeutic Exercise	[30 min]	$0.00	$0.00
[Date]	[92526]	Feeding/Oral Motor Therapy	[45 min]	$0.00	$0.00

Subtotal: $0.00
Adjustments/Insurance: ($0.00)

Total Balance Due: $0.00

NOTES & PAYMENT INSTRUCTIONS

Please make checks payable to [Practice Name]. For bank transfers or credit card payments, please use the following details: [Payment Link/Info].

Thank you for allowing us to support your child's development.