

CLINIC LOGO

[Clinic Name]
[Street Address]
[City, State, Zip]
[Phone Number]
[NPI Number / Tax ID]

INVOICE

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

PATIENT INFO

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

INSURANCE INFO

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

Date of Service	CPT Code	Description of Therapy Service	Amount
[Date]	[97110]	Therapeutic Exercise	\$0.00

Date of Service	CPT Code	Description of Therapy Service	Amount
[Date]	[97112]	Neuromuscular Re-education	\$0.00
[Date]	[97530]	Therapeutic Activities	\$0.00

Subtotal: \$0.00
Insurance Paid: (\$0.00)
Balance Due: \$0.00

Notes: [Insert clinical notes or payment instructions here]

Thank you for choosing us for your child's developmental care.