# INVOICE

Remote Physical Therapy Services

INVOICE DETAILS

No: ___________
Date: ___________

PROVIDER

**[Practice Name]**
[Therapist Name, Credentials]
[Address/Contact Info]
[NPI Number]

PATIENT / BILL TO

**[Patient Name]**
[Address]
[Insurance ID / Case #]
[Email Address]

| Date | CPT Code | Description (Telehealth/Remote) | Units | Rate | Total |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Subtotal: $0.00
Tax: $0.00
Amount Due: $0.00

PAYMENT INSTRUCTIONS & NOTES

Accepted Methods: [Bank Transfer / Credit Card / Online Portal]

Payment is due within [Number] days. Please include the invoice number with your payment.

*Place of Service: 02 (Telehealth) / 10 (Telehealth Provided in Patient's Home)*