INVOICE

Provider: [Practice Name / Therapist Name]

[Address Line 1]
[City, State, Zip]
Phone: [Phone Number]

NPI: [Provider NPI Number]

Invoice #: [00000]

Date: [MM/DD/YYYY]

BILL TO:

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

INSURANCE INFO:

[Payer Name]
ID: [Member ID Number]
Claim #: [Optional]

Date of Service	CPT Code	Description of Service	Units	Rate	Amount
[Date]	97161	PT Evaluation: Low Complexity	1	$0.00	$0.00

Date of Service	CPT Code	Description of Service	Units	Rate	Amount
[Date]	97110	Therapeutic Exercise (15 min)	[Qty]	$0.00	$0.00
[Date]	97116	Gait Training (15 min)	[Qty]	$0.00	$0.00
[Date]	97530	Therapeutic Activities (15 min)	[Qty]	$0.00	$0.00

Subtotal: $0.00

Insurance Paid: ($0.00)

TOTAL BALANCE DUE: $0.00

Payment Terms: Due within [30] days of invoice date.

Notes: [Space for clinical notes or progress summary]

Thank you for choosing our geriatric rehabilitative services.

Please make checks payable to: [Business Name]