INVOICE

[Therapist/Agency Name]
[License Number]
[Address]
[Phone / Email]

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

BILL TO:
[Patient Name]
[Patient Address]
[Policy/ID Number]

REFERRING PHYSICIAN:
[Physician Name]
[NPI Number]

Date of Service	CPT Code / Description	Units/Qty	Rate	Total
[Date]	97161 - PT Evaluation	1	$0.00	$0.00
[Date]	97110 - Therapeutic Exercise	[Qty]	$0.00	$0.00
[Date]	97112 - Neuromuscular Re-ed	[Qty]	$0.00	$0.00
[Date]	97530 - Therapeutic Activities	[Qty]	$0.00	$0.00

Subtotal: $0.00

Tax: $0.00

Total Amount Due: $0.00

Notes: [Diagnosis codes, POC dates, or travel fees]

Payment Instructions: Please make checks payable to [Name] or pay via [Method].