

[CLINIC/THERAPIST NAME]

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

INVOICE # [0000]

DATE [MM/DD/YYYY]

CLIENT / PATIENT [Patient Name]

[Patient Address]

[Phone/Email]

SESSION DETAILS **Provider:** [Therapist Name]

Date of Service: [MM/DD/YYYY]

Duration: [Duration] minutes

CPT/Service Code	Description of Treatment	Rate	Amount
[Code]	[e.g., Manual Therapy / Joint Mobilization]	[\$[0.00]]	[\$[0.00]]
[Code]	[e.g., Myofascial Release / Assessment]	[\$[0.00]]	[\$[0.00]]

Subtotal: \$[0.00]

Tax: \$[0.00]

Total Balance Due: \$[0.00]

Payment Terms: Due upon receipt. Please make checks payable to [Business Name].

Notes: This document serves as a receipt for manual therapy services rendered.