

# INVOICE

Mobile Physical Therapy Services

Invoice #: \_\_\_\_\_

Date: \_\_\_\_\_

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## Provider Details:

Therapist Name: \_\_\_\_\_

License ID: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## Patient Details:

Name: \_\_\_\_\_

Treatment Location: \_\_\_\_\_

Referral MD: \_\_\_\_\_

Date of Service	CPT Code / Description	Duration	Rate	Amount

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	Travel / Mobile Convenience Fee	-		
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Subtotal: \$ \_\_\_\_\_

Tax: \$ \_\_\_\_\_

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**Total Due: \$ \_\_\_\_\_**

**Payment Terms:** Due upon receipt.

**Notes:** \_\_\_\_\_

Thank you for choosing mobile therapy for your recovery.