

# NEUROLOGICAL PHYSICAL THERAPY

[Clinic Name]  
[Street Address]  
[City, State, Zip]  
[Phone Number] | [NPI Number]

## INVOICE

Invoice #: [0000]  
Date: [Date]  
Due Date: [Date]

### PATIENT INFORMATION [Patient Full Name]

[Patient Address]  
[Phone Number]  
DOB: [MM/DD/YYYY]  
INSURANCE / PROVIDER Provider: [Physician Name]  
Insurance ID: [ID Number]  
Auth #: [Number]  
ICD-10: [Primary Diagnosis Code]

Date	CPT Code / Description	Units	Rate	Total
[Date]	97161 - PT Evaluation (Neurological) Moderate Complexity	1	\$0.00	\$0.00
[Date]	97112 - Neuromuscular Re-education Balance, coordination, kinesthetic sense	[Qty]	\$0.00	\$0.00
[Date]	97116 - Therapeutic Procedure (Gait Training) Stair climbing / Ambulation	[Qty]	\$0.00	\$0.00

Date	CPT Code / Description	Units	Rate	Total
[Date]	97530 - Therapeutic Activities Dynamic functional activities	[Qty]	\$0.00	\$0.00

Subtotal: \$0.00  
Insurance Paid: (\$0.00)  
Amount Due: \$0.00

**Payment Instructions:** Please make checks payable to [Clinic Name]. For electronic transfers, use [Transfer Details].

*Note: This document serves as a medical invoice for neurological rehabilitation services rendered.*