THERAPY INVOICE

Practice Name

Address / Phone

NPI Number / Tax ID

Invoice #: ____________
Date: ____________

PATIENT INFORMATION

Name:
ID/DOB:
Address:

BILLING INFORMATION

Payer:
Policy #:
Auth #:

Date of Service	CPT Code	Description (OT/PT)	Units/Qty	Rate	Total

Subtotal: $____________
Insurance Paid: $____________
Patient Responsibility: $____________
Amount Due: $____________

NOTES / TREATMENT CODES

Diagnosis (ICD-10): ____

Provider Signature: ______________________________________ Date: ______________

Thank you for choosing our therapy services.