

TREATMENT INVOICE

Invoice #: []

Date: []

Provider:

[Clinic Name]
[Orthopedic PT Specialist]
[Street Address]
[City, State, Zip]
[NPI Number]

Patient:

[Patient Name]
[Patient ID/DOB]
[Address]
[Insurance Policy #]

DATE OF SERVICE	CPT CODE	DESCRIPTION OF TREATMENT	UNITS	RATE	TOTAL
[/ /]	97161	PT Evaluation: Low Complexity	[]	\$0.00	\$0.00
[/ /]	97110	Therapeutic Exercise	[]	\$0.00	\$0.00
[/ /]	97140	Manual Therapy / Mobilization	[]	\$0.00	\$0.00
[/ /]	97112	Neuromuscular Re-education	[]	\$0.00	\$0.00

Subtotal: \$0.00

Insurance Adjustment: (\$0.00)

Copay/Patient Responsibility: \$0.00

Balance Due: \$0.00

Diagnosis (ICD-10): [Code / Description]

Payment is due within 30 days. Please make checks payable to [Clinic Name].

Note: This document serves as a medical invoice for orthopedic physical therapy services rendered.