# PEDIATRIC THERAPY SERVICES

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

# INVOICE

**Invoice #:** _____
**Date:** _____
**NPI #:** _____

## PATIENT INFORMATION

**Child's Name:** _____
**Date of Birth:** _____
**Parent/Guardian:** _____

## BILLING DETAILS

**Insurance Provider:** _____
**Policy Number:** _____
**Referring MD:** _____

| Date of Service | CPT Code / Description | Duration | Unit Price | Total |
|---|---|---|---|---|
| | Therapeutic Exercise (97110) | | | |

| Date of Service | CPT Code / Description | Duration | Unit Price | Total |
|---|---|---|---|---|
| | Neuromuscular Re-ed (97112) | | | |
| | Therapeutic Activities (97530) | | | |

Subtotal: $0.00
Insurance Paid: ($0.00)
Balance Due: $0.00

**TREATMENT NOTES / ICD-10 CODES**

Please make checks payable to **[Clinic Name]**.

Thank you for choosing us for your child's developmental journey!