INVOICE

Clinic:

Invoice #:

Date:

PATIENT INFORMATION

Name:

ID/DOB:

Address:

PROVIDER INFORMATION

Therapist:

NPI/License:

Referral:

Date of Service	CPT Code / Description	Units/Time	Unit Price	Total
	PT Evaluation (Low/Mod/High Complexity)		$	$
	Therapeutic Exercise (97110)		$	$
	Manual Therapy (97140)		$	$
	Neuromuscular Re-ed (97112)		$	$

Subtotal: $__________

Insurance Adjustment: ($_________)

Balance Due: $_________

Diagnosis Codes (ICD-10): ____

Notes: ____

Payment is due within 30 days. Please make checks payable to the clinic name listed above.