

# PT TREATMENT INVOICE

**Provider:** [Clinic Name]  
[Address Line 1]  
[City, State, Zip]  
[Tax ID / NPI Number]

**Invoice #:** [0000]  
**Date:** [MM/DD/YYYY]  
**Due Date:** [MM/DD/YYYY]

**Patient Information:**

[Patient Full Name]  
[Patient Address]  
[Phone Number]

**Insurance (if applicable):**

[Insurance Provider]  
[Policy Number]  
[Claim Number]

Date of Service	CPT Code	Description of Treatment	Units	Rate	Amount

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

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**Total Due: \$0.00**

Notes / Diagnosis Codes (ICD-10): \_\_\_\_\_

Please make checks payable to **[Clinic Name]**. For billing inquiries, contact **[Phone/Email]**.