

# INVOICE

[Clinic Name]  
[Address Line 1]  
[City, State, Zip]  
[License # / NPI #]

**Invoice #:** \_\_\_\_\_  
**Date:** \_\_\_\_\_  
**Due Date:** \_\_\_\_\_

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## **Patient Information:**

[Patient Full Name]  
[Address]  
[Phone Number]  
[Insurance Provider / ID Number]

## **Treatment Details:**

**Therapist:** \_\_\_\_\_  
**Referral MD:** \_\_\_\_\_  
**ICD-10 Code(s):** \_\_\_\_\_

Date of Service	CPT Code / Description of Service	Units	Rate	Amount
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Subtotal: \$0.00  
Tax/Fees: \$0.00  
Total Amount Due: \$0.00

Please make checks payable to: [Clinic Name]

Thank you for choosing our physical therapy services for your rehabilitation needs.