

INVOICE

Post-Operative Physical Therapy

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

PATIENT INFORMATION

[Patient Name]
[Patient ID / Case #]
[Surgery Date]
[Referring Surgeon]

INVOICE DETAILS

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

Date	CPT Code / Description	Units	Rate	Amount
[Date]	Initial Post-Op Evaluation	1	\$0.00	\$0.00
[Date]	Therapeutic Exercise (97110)	[Qty]	\$0.00	\$0.00
[Date]	Manual Therapy (97140)	[Qty]	\$0.00	\$0.00
[Date]	Neuromuscular Re-ed (97112)	[Qty]	\$0.00	\$0.00

Subtotal: \$0.00
Insurance Adjustment: (\$0.00)
Total Balance: \$0.00

Notes: Please include invoice number with payment. Recovery protocols followed as per surgical instructions.

Terms: Payment due within 30 days of invoice date.