[Practice Name]

[Provider Name, Credentials]
[Address Line 1]
[City, State, Zip]
[Phone] | [Email]
NPI: [Number]

INVOICE

Invoice #: [0000]
Date: [Date]
Due Date: [Date]

BILL TO:

[Patient Name]
[Patient Address]
[City, State, Zip]

INSURANCE (If applicable):

Provider: [Name]
ID #: [Number]
Auth #: [Number]

Date of Service	CPT Code	Description of Service	Units	Rate	Total
[MM/DD/YY]	[97110]	Therapeutic Procedure (Exercise)	[0]	$0.00	$0.00
[MM/DD/YY]	[97140]	Manual Therapy Techniques	[0]	$0.00	$0.00
[MM/DD/YY]	[97112]	Neuromuscular Re-education	[0]	$0.00	$0.00

Subtotal: $0.00
Insurance Paid: ($0.00)

Balance Due: $0.00

Payment Instructions: Please make checks payable to [Practice Name] or pay online via [Link/Portal].

Notes: [Diagnosis Code / ICD-10: 00.00]

Thank you for choosing [Practice Name] for your rehabilitation needs.