

[Clinic Name]

[Street Address]
[City, State, Zip]
[Phone Number]
[Tax ID/NPI Number]

INVOICE

Date: _____
Invoice #: _____

Patient Information:

[Patient Name]
[Address]
[Phone Number]
DOB: [MM/DD/YYYY]

Billing Details:

Insurance: [Provider Name]
Policy #: [ID Number]
Referring MD: [Doctor Name]

Date of Service	CPT Code	Description of Treatment/Modality	Units	Rate	Amount

Subtotal: \$0.00
Insurance Adjustments: (\$0.00)
Copay/Patient Paid: (\$0.00)

Total Balance Due: \$0.00

Payment Terms: Please remit payment within 30 days. Checks payable to [Clinic Name].

Notes: All treatments provided by a licensed Physical Therapist. ICD-10 Diagnosis Code: _____