REHABILITATION CLINIC

[Clinic Address Line 1]
[City, State, Zip]
[Phone Number]
[Email/Website]

INVOICE

Invoice #: _____

Date: _____

Due Date: _____

PATIENT INFORMATION

Name: _____

ID: _____

Address: _____

INSURANCE INFO

Provider: _____

Policy #: _____

Referral: _____

Date of Service	CPT Code / Description	Qty/Units	Unit Price	Total
	Initial Evaluation			
	Therapeutic Exercise (97110)			

Date of Service	CPT Code / Description	Qty/Units	Unit Price	Total
	Manual Therapy (97140)			
	Neuromuscular Re-ed (97112)			

Subtotal: $ _____

Insurance Adjustment: ($ _____)

Amount Paid: ($ _____)

Balance Due: $ _____

Notes: _____

Please make all checks payable to [Clinic Name]. Payment is due within 30 days. Thank you for choosing our clinic for your recovery.