

INVOICE

SPORTS PT CLINIC NAME
123 Performance Way, Suite 100
City, State, Zip Code

Invoice #: _____
Date: _____
Due Date: _____

BILL TO:

Patient Name: _____
Address: _____
Phone: _____

SESSION DETAILS:

Provider: _____
Referral Ref: _____
Auth #: _____

Date of Service	CPT Code / Description	Units/Qty	Rate	Total
	Initial Sports Assessment		\$	\$
	Therapeutic Exercise (97110)		\$	\$
	Manual Therapy (97140)		\$	\$
	Neuromuscular Re-ed (97112)		\$	\$

Subtotal: \$ _____

Insurance Paid: -\$ _____

Patient Co-pay: \$ _____

Balance Due: \$ _____

Notes: _____

Please make checks payable to **Sports PT Clinic Name**.
Payment is due within 30 days of service. Thank you for choosing us for your recovery and performance.