WELLNESS CENTER

[Address Line 1]
[City, State, Zip]
[Phone Number]

INVOICE

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

BILL TO:
[Patient Name]
[Patient Address]
[Insurance Provider / ID]

PROVIDER:
[Therapist Name]
[NPI Number]

Date of Service	CPT Code / Description	Units	Rate	Amount
[Date]	*[97110 - Therapeutic Exercise]*	*[0]*	*[$0.00]*	*[$0.00]*
[Date]	*[97140 - Manual Therapy]*	*[0]*	*[$0.00]*	*[$0.00]*
[Date]	*[97112 - Neuromuscular Re-ed]*	*[0]*	*[$0.00]*	*[$0.00]*

Subtotal: *[$0.00]*
Insurance Paid: *[$0.00]*
Balance Due: *[$0.00]*

Notes:

[Enter payment terms or clinical notes here]

Thank you for choosing Wellness Center Physical Therapy.