[Clinic Name]

[Clinic Address]
[City, State, Zip]
[Phone Number]
[Provider NPI Number]

INVOICE

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

Bill To:

[Patient Name]
[Patient Address]
[City, State, Zip]
[Insurance ID if applicable]

Provider Details:

Attending: [Practitioner Name]
Tax ID: [XX-XXXXXXX]

Date of Service	CPT/Code	Description of Service	Units	Amount
[MM/DD/YY]	99203	New Patient Evaluation	1	$0.00
[MM/DD/YY]	98940	Chiropractic Treatment (1-2 Regions)	1	$0.00
[MM/DD/YY]	97110	Therapeutic Exercise (15 min)	[X]	$0.00

Date of Service	CPT/Code	Description of Service	Units	Amount
[MM/DD/YY]	97014	Electrical Stimulation	1	$0.00

Subtotal: $0.00

Insurance Paid: ($0.00)

Balance Due: $0.00

Notes / Payment Instructions:

Please make checks payable to [Clinic Name]. Payments are due within [30] days. All diagnostic and procedure codes are provided for insurance reimbursement purposes.