[Clinic Name]

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

INVOICE

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

PATIENT INFORMATION

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

INSURANCE DETAILS

Provider: [Insurance Co. Name]
Policy #: [ID Number]
Group #: [Group Number]

Date of Service	CPT Code	Description of Service	Amount
[Date]	[99203]	Initial Office Visit / Evaluation	$0.00
[Date]	[98940]	Chiropractic Adjustment (1-2 Regions)	$0.00

Date of Service	CPT Code	Description of Service	Amount
[Date]	[97110]	Therapeutic Exercise	$0.00
[Date]	[97014]	Electrical Stimulation (Unattended)	$0.00

Subtotal: $0.00
Insurance Paid: ($0.00)
Adjustments: ($0.00)

Total Due: $0.00

Diagnosis Codes (ICD-10): [M54.5, M54.2, etc.]

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

Thank you for choosing our clinic for your spinal health.