CHIROPRACTIC CLINIC NAME

123 Wellness Way, Suite 100
City, State, Zip Code
Phone: (555) 000-0000
NPI: 0000000000

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

PATIENT INFORMATION

Name: _____
ID #: _____
Address: _____
Phone: _____

INSURANCE INFORMATION

Provider: _____
Policy #: _____
Group #: _____
Auth #: _____

Date of Service	CPT Code	Description of Procedure / Modality	Units	Charge
	99203	Initial Evaluation / Exam	1	$
	98940	Chiropractic Manipulative Treatment (1-2 regions)	1	$
	98941	Chiropractic Manipulative Treatment (3-4 regions)	1	$

Date of Service	CPT Code	Description of Procedure / Modality	Units	Charge
	97110	Therapeutic Exercise (15 min)		$
	97014	Electrical Stimulation (Unattended)	1	$

Gross Charges: $ _____
Insurance Adjustments: ($ _____)
Patient Co-pay/Deductible: $ _____
Total Amount Due: $ _____

Please make checks payable to: Clinic Name. Payments are due within 30 days of invoice date.

Diagnosis Codes (ICD-10): _____

Authorized Provider Signature: _____ Date: _____