SPINAL ALIGNMENT THERAPY

Practice Name / Clinic

Address Line 1

Contact Number / Email

INVOICE NO.

#

DATE

MM/DD/YYYY

PATIENT INFORMATION

Name:

Patient ID:

Phone:

PRACTITIONER

Dr. / Therapist Name:

License No:

Referral Ref:

Service Description	ICD-10 / CPT Code	Qty	Rate	Total
Initial Spinal Assessment				

Service Description	ICD-10 / CPT Code	Qty	Rate	Total
Manual Spinal Adjustment				
Therapeutic Exercises				

Subtotal $0.00
Tax $0.00
TOTAL DUE $0.00

NOTES / CLINICAL OBSERVATIONS

Payment is due within 15 days. Thank you for choosing our practice for your spinal health.