SPORTS INJURY CHIROPRACTIC

[Clinic Address Line 1]
[City, State, Zip]
Phone: (000) 000-0000

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____
Address: _____
Phone: _____

INSURANCE / CLAIM DETAILS

Provider: _____
Policy #: _____
Claim #: _____

Date of Service	Procedure Code (CPT)	Description of Service / Treatment	Amount

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Subtotal: $ _____
Insurance Adjustment: ($ _____)
Total Due: $ _____

NOTES & INSTRUCTIONS

Provider NPI: _____ | Tax ID: _____

Please make checks payable to: **Sports Injury Chiropractic**

Terms: Payment is due within 30 days of service. Thank you for choosing us for your recovery.