

# [Practice Name]

Geriatric Physical Therapy Services  
[Street Address]  
[City, State, Zip]  
[Phone Number] | [NPI Number]

# INVOICE

Invoice #: \_\_\_\_\_  
Date: \_\_\_\_\_

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## PATIENT INFORMATION

[Patient Full Name]  
[Address]  
[Phone Number]  
[Date of Birth]

## INSURANCE / BILLING

Medicare/ID #: \_\_\_\_\_  
Referring MD: \_\_\_\_\_  
Diagnosis Code (ICD-10): \_\_\_\_\_

Date of Service	CPT Code	Description of Therapy Service	Units	Rate	Amount

Subtotal: \$ \_\_\_\_\_

**Insurance Paid:** (\$ \_\_\_\_\_)

**TOTAL BALANCE DUE:** \$ \_\_\_\_\_

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**Notes / Special Instructions:**

[e.g., Next appointment date, home exercise reminders, or payment terms]

Thank you for choosing us for your rehabilitation and mobility needs.