[Clinic Name]

Physical Medicine & Rehabilitation
[Street Address]
[City, State, Zip]
[Phone Number]

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____
ID: _____
DOB: _____

INSURANCE INFORMATION

Provider: _____
Policy #: _____
Auth #: _____

Date of Service	CPT Code	Description of Service	Units	Amount
		Evaluation / Follow-up		
		Therapeutic Exercise		
		Neuromuscular Re-education		

Date of Service	CPT Code	Description of Service	Units	Amount
		Manual Therapy		
		Other: _____		

Subtotal: $ _____
Insurance Paid: - $ _____
Copay/Deductible: $ _____
Total Balance Due: $ _____

Payment Terms: Due within 30 days. Please make checks payable to "[Clinic Name]".

Provider NPI: _____ | **Tax ID:** _____