

PHYSICAL THERAPY INVOICE

[Clinic Name]

[Address / Phone]

INVOICE #
DATE

PATIENT INFORMATION

Name:

ID/DOB:

Referral MD:

INSURANCE / PROVIDER INFO

NPI Number:

Insurance Group:

Policy Number:

Date of Service	CPT Code	Description of Therapy	Units	Rate	Total
		Initial Evaluation			
		Therapeutic Exercise			
		Manual Therapy			
		Neuromuscular Re-ed			

Subtotal: \$0.00

Insurance Paid: (\$0.00)

Patient Balance: \$0.00

ICD-10 DIAGNOSIS CODES

Notes: _____

Thank you for choosing our rehabilitation services.