INVOICE

PROVIDER INFORMATION

Clinic / Provider:

NPI / License:

Address:

Phone / Email:

PATIENT INFORMATION

Patient Name:

Date of Birth:

Insurance Provider:

Policy / Group ID:

INVOICE NUMBER

INVOICE DATE

PAYMENT DUE DATE

CLAIM REFERENCE

DATE	CPT CODE	THERAPY DESCRIPTION / SERVICE TYPE	UNITS	UNIT RATE	TOTAL AMOUNT

NOTES / PAYMENT TERMS

Subtotal: _____

Insurance Paid: _____

Copay / Coinsurance: _____

Patient Balance Due:

THERAPIST / AUTHORIZED REPRESENTATIVE SIGNATURE

PATIENT / RESPONSIBLE PARTY SIGNATURE