PHYSICAL THERAPY INVOICE

Clinic Name

Clinic Address

Phone / Email

Patient & Billing Information

Patient Name

Patient Address

Invoice Date

Invoice Number

Date of Service

Physician / PT Name

Patient ID

Services Provided

Service/Procedure	CPT Code	Units	Rate	Amount

Subtotal: _____

Tax: _____

Total: _____

Amount Paid: _____

Balance Due: _____

Notes / Payment Terms

Authorized Signature

_____