



Invoice for Medical Record Requests

Patient/Client:

SSN:

DOB:

Case #:

Please pay the amount indicated for the service(s) you are requesting. We will process immediately upon receipt of payment. Please check all boxes that apply.

- | | |
|---|--------------------|
| <input type="checkbox"/> Medical records preparing, copying and mailing: | \$35 |
| <input type="checkbox"/> Medical records preparing for copy service (no mailing): | \$15 |
| <input type="checkbox"/> Final Medical Bills Invoice: | \$25 |
| <input type="checkbox"/> Professional Consult fee: | Please call |
| <input type="checkbox"/> Court Appearance/Expert Witness Services | \$400/hr |
| <input type="checkbox"/> Physical Therapy Narrative Report | \$300 |

Total Due \$_____

Make all checks payable to: **STAR Rehab Corp**
PO Box 79396
Corona, CA 92877
1.800.280.1339

For any questions please email us at records@star-pt.com. Thank you.

Sincerely,

A handwritten signature in black ink that reads "James Ko P.T." in a cursive style.

James Ko, MPT
President
Star Rehabilitation Corp
Tax ID # 65-1240569

"Experts in Relieving Pain and Injury."