SERVICE INVOICE

Invoice Number
#_____

Date
___ / ___ / 20___

Provider
[Studio Name]
[Address Line 1]
[Phone Number]

Client
[Client Name]
[Client Phone / Email]
[Membership ID, if applicable]

Facial Therapy Service / Treatment	Duration	Price
_____	_____ min	$_____
_____	_____ min	$_____
Add-on: _____	-	$_____

Subtotal $_____
Tax $_____

Total Due $_____

Notes & Aftercare

_____

Payment Status

[ ] Cash [ ] Credit Card [ ] Other: _____