INVOICE

Student Assessment Services

Invoice #: _____
Date: _____

PROVIDER INFORMATION

[Company/Consultant Name]
[Street Address]
[City, State, Zip]
[Phone/Email]

BILL TO

[Student/Parent Name]
[Institution/School Name]
[Address]
[Student ID, if applicable]

Service Description	Date of Service	Rate/Unit	Total
Initial Educational Consultation			
Cognitive/Academic Testing			
Report Writing & Documentation			
Follow-up Results Meeting			

Subtotal: $0.00
Tax/Fees: $0.00

Total Amount: $0.00

NOTES & PAYMENT INSTRUCTIONS

Please make checks payable to [Business Name]. For electronic transfers, use [Payment Details]. Payments are due within [Number] days of invoice date.