INVOICE

[High School Name]
Counseling Department
[Street Address]
[City, State, Zip]

Invoice #: *[000]*
Date: *[MM/DD/YYYY]*
Due Date: *[MM/DD/YYYY]*

Bill To:

[Parent/Guardian Name]
[Student Name / ID]
[Address]
[City, State, Zip]

Service Description	Date	Hours/Qty	Rate	Amount
[Academic Planning / Personal Counseling]	*[Date]*	*[0.0]*	$0.00	$0.00
[College Application Workshop]	*[Date]*	*[0.0]*	$0.00	$0.00

Subtotal: $0.00

Tax: $0.00

Total Balance Due: $0.00

Notes: [Insert payment instructions or school policy here]

Thank you for supporting our student services.