

# INVOICE

**[Specialist Name/Business]**

[Address Line 1]

[City, State, Zip]

[Email/Phone]

**Invoice #:** [000]

**Date:** [Date]

**Due Date:** [Date]

**BILL TO:**

[Client Name]

[Client Address]

[Client Phone]

**PROGRAM TYPE:**

[Postpartum Recovery / Corrective Exercise / Strength Training]

| Session Date | Description                                  | Duration | Rate   | Amount |
|--------------|--|----------|--------|--------|
| [Date]       | [e.g., Core & Pelvic Floor Assessment]       | [60 Min] | \$0.00 | \$0.00 |
| [Date]       | [e.g., Postpartum Personal Training Session] | [60 Min] | \$0.00 | \$0.00 |
| [Date]       | [e.g., Diastasis Recti Follow-up]            | [45 Min] | \$0.00 | \$0.00 |

Subtotal: \$0.00

Tax: \$0.00

**Total Due: \$0.00**

**Payment Instructions:** [Zelle, Venmo, or Bank Transfer Details]

Thank you for allowing me to support your postpartum wellness journey.