[CONSULTANCY NAME]

Healthcare Strategy & Operations
[Street Address]
[City, State, Zip]
[Email/Phone]

INVOICE

Invoice #: [0000]
Date: [Date]
Due Date: [Date]

BILL TO:

[Client Healthcare System/Hospital]
[Attn: Department/Contact]
[Street Address]
[City, State, Zip]

PROJECT REFERENCE:

[Project Name/Engagement Code]
[Purchase Order Number]

Service Description	Hours/Units	Rate	Total
Operational Efficiency Analysis - Phase 1	[0.00]	$[0.00]	$[0.00]
Clinical Workflow Strategy Consulting	[0.00]	$[0.00]	$[0.00]
Regulatory Compliance Audit	[0.00]	$[0.00]	$[0.00]

Service Description	Hours/Units	Rate	Total
Administrative Expenses (Reimbursable)	[1]	$[0.00]	$[0.00]

Subtotal: $[0.00]
Tax/VAT: $[0.00]
Balance Due: $[0.00]

PAYMENT INSTRUCTIONS

Please make checks payable to **[Consultancy Name]**.
Wire Transfer: [Bank Name] | Routing: [Number] | Account: [Number]
Late fees may apply according to terms of the Master Service Agreement.