

INVOICE

[Consulting Firm Name]
[Healthcare Practice Address]
[City, State, Zip]
[Email/Phone]

INVOICE NUMBER #[0000]
DATE ISSUED [MM/DD/YYYY]
DUE DATE [MM/DD/YYYY]

CLIENT / HEALTH SYSTEM **[Client Name/Organization]**
[Department/Contact Person]
[Street Address]
[City, State, Zip]
PROJECT REFERENCE **[Project Title/Code]**
[Purchase Order #]
[Consultant Name]

| Project Task / Milestone Description | Hours/Qty | Rate/Unit | Line Total |
|--|-----------|------------|------------|
| [e.g., EMR Implementation Oversight - Phase 1] | [0.00] | [\$[0.00]] | [\$[0.00]] |
| [e.g., Clinical Workflow Optimization Analysis] | [0.00] | [\$[0.00]] | [\$[0.00]] |
| [e.g., Regulatory Compliance Audit (HIPAA/Joint Commission)] | [0.00] | [\$[0.00]] | [\$[0.00]] |

Subtotal: \$[0.00]
Expenses/Adjustments: \$[0.00]

Total Amount Due: \$[0.00]

PAYMENT INSTRUCTIONS

Please make all checks payable to **[Consulting Firm Name]**.
For Wire/ACH: [Bank Name] | Account: [Number] | Routing: [Number]
Terms: Net [30] days. Late payments may be subject to a [0]% fee.