CONSULTATION ESTIMATE

[Consultant Name/Firm]
[Street Address]
[City, State, Zip]
[NPI Number / Tax ID]

Estimate #: [000]
Date: [MM/DD/YYYY]
Valid Until: [MM/DD/YYYY]

CLIENT / HEALTHCARE FACILITY

[Organization Name]
[Contact Person]
[Address]
[Email/Phone]

PROJECT REFERENCE

[Project Name/Scope]
Projected Start: [Date]
Estimated Duration: [Weeks/Months]

Service Description	Rate Type	Qty/Hrs	Unit Price	Total
[Strategic Planning / Compliance Audit]	[Hourly/Flat]	[0.00]	$0.00	$0.00
[Revenue Cycle Management Analysis]	[Hourly/Flat]	[0.00]	$0.00	$0.00
[Staff Training & Implementation]	[Hourly/Flat]	[0.00]	$0.00	$0.00

Subtotal: $0.00

Estimated Expenses: $0.00
Estimate Total: $0.00

TERMS & CONDITIONS

1. This is an estimate only, not a final invoice. Final costs may vary based on actual hours worked and scope changes.
2. Reimbursable expenses (travel, lodging, materials) are billed at cost unless otherwise specified.
3. Payment terms: [Net 30] upon receipt of final invoice.