

# FEE ESTIMATE

**Provider:**

**Date:**

Estimate #: \_\_\_\_\_

**Client Name:**

**Consultation Type:**

Description of Services	Estimated Hours/Units	Rate	Amount
Initial Wellness Assessment			
Follow-up Consultation			
Nutritional Planning			
Laboratory Review Fee			
<b>Estimated Total:</b>			<b>\$</b>

**Terms and Conditions:**

1. This is an estimate only and not a final invoice.
2. Final costs may vary based on actual duration and additional services requested.
3. Estimate valid for 30 days from the date issued.

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Authorized Signature: \_\_\_\_\_

Thank you for choosing our wellness services.