

## [Clinic Name]

[Street Address]  
[City, State, Zip]  
[Phone Number]  
[Email/Website]

## INVOICE

Date: [MM/DD/YYYY]  
Invoice #: [00000]

### PATIENT:

[Patient Name]  
[Patient Address]  
[Patient Phone]

### PRACTITIONER:

[Provider Name]  
[License/NPI Number]

Service / Supplement	Quantity	Unit Price	Amount
[Holistic Consultation / Acupuncture / Therapy]	[0]	[\$0.00]	[\$0.00]
[Herbal Formulas / Supplements]	[0]	[\$0.00]	[\$0.00]

Service / Supplement	Quantity	Unit Price	Amount
[Diagnostic Testing / Lab Fees]	[0]	[\$0.00]	[\$0.00]
Subtotal: [\$0.00]			
Tax: [\$0.00]			

**Total Due: [\$0.00]**

**Notes & Instructions:**

Payment is due within [Number] days. Please make checks payable to [Clinic Name]. This document may be used for insurance reimbursement claims if applicable.

*Thank you for choosing a holistic approach to your wellness.*