

CRANIOSACRAL THERAPY

[Practitioner Name]
[Business Address]
[Phone Number]
[Email/Website]

INVOICE

Date: [00/00/0000]
Invoice #: [000]

Client:

[Client Name]
[Client Address]
[Client Phone]

Payment Details:

Due Date: [Date]
Status: [Unpaid/Paid]

Date of Service	Description of Treatment	Duration	Amount
[00/00/0000]	Craniosacral Therapy Session	[60 Min]	\$0.00
[00/00/0000]	[Additional Service/Follow-up]	[30 Min]	\$0.00

Subtotal: \$0.00

Tax: \$0.00

Total Due: \$0.00

Payment Instructions: [Bank Transfer / Check / Cash / Online]

Thank you for your commitment to your health and well-being.

[License/Certification Number if applicable]