

Integrative Health Practice

[Practice Address Line 1]
[City, State, Zip]
[Phone Number]
[Tax ID/NPI]

INVOICE

Invoice #: [000]
Date: [MM/DD/YYYY]

BILL TO

[Patient Name]
[Patient Address]
[Phone/Email]

PRACTITIONER

[Provider Name]
[Specialty/License]

Service/Product Description	Code (CPT/ICD)	Qty	Unit Price	Amount
[Initial Consultation / Service Name]	[00000]	1	\$0.00	\$0.00
[Supplements / Labs]	-	1	\$0.00	\$0.00

Subtotal: \$0.00
Tax: \$0.00

Total Due: \$0.00

NOTES & PAYMENT INSTRUCTIONS

Please make checks payable to [Practice Name]. Payment is due within [Number] days.

Disclaimer: This invoice is for services rendered and may not be covered by all insurance providers.