NATUROPATHIC CLINIC

[Clinic Address]
[Phone Number]
[Tax ID / NPI Number]

Invoice #: _____
Date: _____

Patient Information:

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

Physician:
[Doctor Name], ND

Service / Item Description	CPT/ICD Code	Qty	Unit Price	Total
Initial Consultation / Follow-up			$	$
Laboratory Testing			$	$
Supplements / Botanical Medicine			$	$
Treatment (Acupuncture/Hydrotherapy/etc)			$	$

Subtotal: $_____
Tax: $_____

Total Due: $_____

Payment Terms: Due upon receipt. Please make checks payable to [Clinic Name].

Notes: This invoice may be used for insurance reimbursement purposes. Diagnosis codes available upon request.