[Clinic Name]

[Practitioner Name, DC]
[Street Address]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____

BILL TO:

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

SESSION INFO:

Provider: [Name]
NPI #: [Number]
Tax ID: [Number]

Service/Product Code	Description	Qty/Units	Rate	Amount
99401	Nutritional Counseling - Initial Session	1	$	$
99402	Nutritional Counseling - Follow-up		$	$
SUPP	Clinical Supplements / Whole Food Concentrates		$	$

Service/Product Code	Description	Qty/Units	Rate	Amount
LAB	Functional Lab Testing/Panel		$	$

Subtotal: $ _____
Tax: $ _____
Total Due: $ _____

Notes:

[Clinical recommendations or follow-up dates]

Payment is due upon receipt of services. Please make checks payable to **[Clinic Name]**.

Disclaimer: Nutritional counseling is provided as a supportive wellness service and is not intended to diagnose or treat specific medical diseases.