Pediatric Wellness Chiropractic

[Clinic Address Line 1]
[City, State, Zip]
[Phone Number]

INVOICE

Date: [Date]
Invoice #: [0000]

PATIENT INFORMATION

[Child's Full Name]
Parent/Guardian: [Name]
DOB: [Date of Birth]

BILLING TO

[Responsible Party Name]
[Address Line 1]
[Email Address]

Service Date	Description of Service	ICD-10 / CPT	Amount
[Date]	Pediatric Chiropractic Adjustment	[Code]	$0.00
[Date]	Developmental Wellness Assessment	[Code]	$0.00
[Date]	Nutritional Consultation (Pediatric)	[Code]	$0.00

Subtotal: $0.00

Discount/Insurance: ($0.00)

Total Balance Due: $0.00

Payment is due upon receipt. We accept Cash, Credit Cards, and HSA/FSA Accounts.

Thank you for choosing us for your child's wellness journey.