Hormone Therapy Program

123 Wellness Way
Medical Suite 400
Contact: (555) 010-9988

INVOICE

Date: _____
Invoice #: _____

Patient Information:

Name: _____
ID: _____
Address: _____

Physician / Provider:

Dr. _____
License: _____

Description of Services / Medication	Quantity	Unit Price	Total
Initial Hormone Lab Panel (Bloodwork)			
Clinical Consultation & Assessment			
Hormone Replacement Medication (Monthly Supply)			

Description of Services / Medication	Quantity	Unit Price	Total
Injection Supplies / Delivery Kit			
Follow-up Monitoring & Telehealth			

Subtotal: $_____
Tax: $_____

Grand Total: $_____

Payment Terms: Payment due within 15 days. Please make checks payable to "Hormone Therapy Program".

Notice: This invoice may be used for HSA/FSA reimbursement claims. Please consult your insurance provider regarding coverage eligibility for hormone replacement therapy.