INTEGRATIVE ONCOLOGY CARE

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

INVOICE

Invoice #: [0000]
Date: [Date]

Patient Information:

[Patient Name]
[Patient ID]
[Address Line 1]
[City, State, Zip]

Referring Provider:

[Doctor Name]
[NPI Number]
Due Date: [Date]

Service Description	CPT Code	Qty/Hrs	Unit Price	Total
Initial Integrative Consultation	99204	1	$0.00	$0.00
IV Vitamin/Nutrient Therapy	J7030	1	$0.00	$0.00
Acupuncture for Oncology Support	97810	1	$0.00	$0.00

Service Description	CPT Code	Qty/Hrs	Unit Price	Total
Dietary & Supplement Protocol Review	99401	1	$0.00	$0.00

Subtotal: $0.00

Tax / Adjustments: $0.00

Total Due: $0.00

Payment Instructions: Please make checks payable to [Clinic Name]. Payments are due within 30 days.

Note: Integrative therapies may not be covered by all insurance providers. Please check with your carrier for reimbursement eligibility.