220-04 Linden Blvd. • Cambria Heights, NY 11411• Tel: 718-712-3358 • Fax: 718-712-3379

SERVICE INVOICE

Invoice Number:_____
Invoice Date: _____
Therapist's Name: _____
SS #/NPI#: _____
Address: _____
Telephone/Fax: _____

Discipline (circle appropriate disc.): **SI** **OT** **PT** **ST** **TSHH** **SW** **PSYCH**

Total Sessions _____ **Total Due:** _____

Child's Name	EI #	Date	Time In	Time Out	Rate
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Therapist's Signature: _____ **Date:** _____