

Payroll # _____

All About Kids NPI# 1669513404

Evaluations & Therapy
255 Executive Drive Ste. LL105 Plainview, NY 11803
Attn: Finance Department

Tel: 516-576-0962
Fax: 516-349-0961
Toll Free: 1877333kids

Monthly Evaluation Summary: PRESCHOOL & SCHOOL-AGE ONLY --Revised

PLEASE NOTE: 1) PLEASE FAX OR EMAIL THIS BILL AND YOUR PERSONAL INVOICE BY THE 5th OF NEXT MONTH 2) PLEASE DO NOT COMBINE MULTIPLE BILLING MONTHS ON ONE INVOICE.

Therapist: _____ Therapist Business Name (if applicable) _____

Address: _____

Billing Month _____ 201__

Phone: _____

Email: _____

Child's Name: _____ Sex: _____ D.O.B. ___/___/___

Eval Date: _____ Eval Type: _____ Bilingual Eval?: Y/N ___ Language: _____

County/Borough: _____ CSE (District Name _____)

- Informing _____ (please attach informing form for this child)
 - Translation _____ (for which therapist _____)
 - Other _____
 - Observation _____
 - Meeting Date _____ (please attach meeting form for this child)
- Amount Due \$ _____

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Eval Date: _____ Eval Type: _____ Bilingual Eval?: Y/N ___ Language: _____

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Total amount due for this page \$ _____

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