

Payroll # \_\_\_\_\_

# All About Kids

Pay cycle \_\_\_\_\_

Evaluations & Therapy

Tel: 516-576-0962

255 Executive Drive Ste. LL102 Plainview, NY 11803

Fax: 516-349-0961

Attn: Finance Department

Toll Free: 1877333kids

## NYC Early Intervention Evaluation Monthly Summary Form

DUE DATE - 3<sup>RD</sup> OF NEXT MONTH

PLEASE NOTE: 1) PLEASE MAIL, FAX, OR EMAIL THIS BILL AND YOUR PERSONAL INVOICE BY THE DUE DATE 2) DO NOT COMBINE MULTIPLE BILLING PERIODS ON ONE INVOICE.

Therapist: \_\_\_\_\_ Business Name (if applicable) \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

Mobile# \_\_\_\_\_ Home# \_\_\_\_\_

Email \_\_\_\_\_

Billing Month \_\_\_\_\_ 201\_\_

SERVICE TYPE: (CIRCLE ONE) SP SPED OT PT SW PSYCH NU AUDIO

Child's Name \_\_\_\_\_ Amount Due \$ \_\_\_\_\_

BROOKLYN-EI  BRONX-EI  MANHATTAN-EI  QUEENS-EI (check one)

Check Box if this is a Bilingual evaluation

Informing \_\_\_/\_\_\_/\_\_\_ (please attach informing form for this child)

Evaluation Date \_\_\_/\_\_\_/\_\_\_ is this a  Core or  Non-Supplemental

Translation \_\_\_/\_\_\_/\_\_\_ (for which therapist \_\_\_\_\_)

IFSP Meeting Date \_\_\_/\_\_\_/\_\_\_ (please attach meeting form for this child)

Observation \_\_\_/\_\_\_/\_\_\_  Other \_\_\_\_\_

Child's Name \_\_\_\_\_ Amount Due \$ \_\_\_\_\_

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Observation \_\_\_/\_\_\_/\_\_\_  Other \_\_\_\_\_

Total amount due for this page \$ \_\_\_\_\_

Page \_\_\_\_\_ of \_\_\_\_\_