Payroll # ______

Pay cycle ______

All About Kids

Evaluations & Therapy

255 Executive Drive Ste. LL102 Plainview, NY 11803

Attn: Finance Department

Tel: 516-576-0962

Fax: 516-349-0961

Toll Free: 1877333kids

LONG ISLAND Early Intervention Evaluation Monthly Summary Form

DUE DATE – 3RD 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 $_______

☐Nassau-EI ☐Suffolk-EI (check one)

☐Check Box if this is a Bilingual evaluation

☐Evaluation Date___/___/___ is this a ☐Core or ☐ Non-Supplemental

☐IFSP Meeting Date___/___/___ (please attach meeting form for this child)

☐Informing ___/___/___ (please attach informing form for this child)

☐Translation ___/___/___ (for which therapist ______________)

☐Observation ___/___/___ ☐Other ______________

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☐Observation ___/___/___ ☐Other ______________

Total amount due for this page $ __________

Page _____ of _____