Payroll # _____

All About Kids

Executive Directors
Cathleen A. Grossfeld
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Evaluations & Therapy
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Attn: Finance Department

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Monthly Summary Services: Pre-School Related Services and School-Age Billing

PLEASE NOTE: 1) BILLING IS DUE BY THE 5TH OF THE MONTH 2) DO NOT COMBINE MULTIPLE MONTHS ON ONE INVOICE. 3) PLEASE BILL ON A MONTHLY BASIS TO PREVENT DELAY IN YOUR PAYMENT

Therapist: ______________________________
Address: ______________________________
City________________ State____ zip ______
Mobile#______________ Home#____________
Email ______________________________

Month: __________ 20_____

(CIRCLE ALL THAT APPLIES)

SERVICE TYPE: CPSE: Parent Training SP OT PT SW PSYCH
CSE: SPED/Behav-Int/ABA Parent Training SP OT PT SW PSYCH

Client's Name ____
(CIRCLE ONE)
BXPS BKPS NCPS NYPS SCPS W'CHESTER PS SCHOOL-AGE
(______________) (______________) X (______________) = ______________
Authorized length of session Number of Sessions Session Rate Amount Due

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TOTAL AMOUNT $______________

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