

Payroll # _____

All About Kids NPI# 1669513404

Executives:
Cathleen A. Grossfeld
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Evaluations & Therapy
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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: _____

CPSE County/Borough: _____ CSE (District Name _____)

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

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

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

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Total amount due for this page \$ _____

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