



Billing Information

Client's Name: _____

Parent's Names: _____

Address: _____

Email Addresses: _____

Send bill to:

Child's Birthdate: _____ Age: _____

Pediatrician: _____ Phone: _____

Referred by: _____

Therapist: _____

Diagnosis: _____

Insurance Codes: _____

Insurance Forms: with each month's billing, we can include an insurance form that you may submit to your insurance company for reimbursement.

Please indicate whether you think you will need an insurance form included with your bill:

I do want a form included

I do not want a form included

(also if you choose to receive a form now, just in case, and later find you won't need it, you can let us know to discontinue service)