INVOICE

CLINICIAN: ____
SOC. SEC. # _____________________________________
ADDRESS: ______________________________ **Apt #** ______
CITY: _________________ **STATE:** _______ **ZIP:** __________

MONTH ____________________ YEAR 200__

BILL TO: LOS NIÑOS SERVICES, INC.
535 EIGHTH AVENUE, 2ND FL
NEW YORK, NY, 10018
(tel 212.787.9700)

DATES LEGEND: P - Present NS - No Show CP - Cancelled/Parent CC - Cancelled/Clinician CS - Child Sick M - Make up session (write in date of session being made up, e.g. M 2/24, and write sideways)

CHILD's NAME	SERVICE TYPE CODE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL SESSIONS	FEE PER SESSION	TOTAL AMOUNT
1																																			$ -
2																																			$ -
3																																			$ -
4																																			$ -
5																																			$ -
6																																			$ -
7																																			$ -
8																																			$ -
9																																			$ -
10																																			$ -
11																																			$ -
12																																			$ -

Therapist Signature: ____ **Submission Date:** ____/____/____ **Total** **$ -**

(revised 8/20/04)

(Service Type Code FC = Family Counseling, FT = Family Training, SI = Special Instruction, SL = Speech/Language, OT = Occupational Therapy, PT = Physical Therapy, SW = Social Work, FSG = Family Support Group, V = Vision, Psy = Psychological)