MONTHLY ATTENDANCE SHEET

Please submit all bills to:

Advanced Child Therapies
Billing Office
52 S. Butehorn Street, Bethpage, NY 11714
Fax 1888 833-2331

*Use a separate sheet for each category *Preschool

All bills MUST be received by mail or fax by the 3rd of the following month.

ST	_
70	Tilerapist Name:
PT	st Name
SEIT	
Counseling	
Parent Training	

MONTH:

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for by	cheduled
for by using the co	d treatment days MUST be accounted
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he codes listed below:	be accoun
	ted

- 30 45 -- Thirty minute session
- -- Forty five minute session
- 90 60 -- Ninety minute session -- Sixty minute session
- 120 -- 2 hour session
- Group -- Check Group "G" Box
- DC -- Discharge
- A -- Therapist Absent
- -- CPSE Meeting (30 min) Related Service only -- Child Absent

School Vacation

Vision

All children should be listed in alphabetical order

SIUCENI NAME				_						2	2
LAST	FREQ.	G 1 2	3 4 5	6 7	8 9 10	9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	3 14 15	16 17	18 19	20 21	22 23

DATE

THERAPIST SIGNATURE: