Claim & Payment Form

(Under session type please indicate Consultation - C, Individual - I, Couples - Cp, Group - G, Family – F)

Therapist _____

Date of Service	Patient Name	Session Type	Payment Made	Cash/ Check#	Fee/ Co-pay
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		
			$		

Phone 718.493.4785 Fax 718.493.3237 Email info@billersinc.com