Amerimed Early Intervention Program

200 WEST 58TH STREET NEW YORK NY 10019 Tel: 718-339-4000 Fax: 718-339-7203

COMPANY NAME: _____

THERAPIST'S NAME: _____

SPECIALITY: _____ **TAX ID/SS:** _____

ADDRESS: _____

_____

INVOICE FOR SERVICES RENDERED TO **AMERIMED EARLY INTERVENTION PROGRAM**

# OF SESSIONS	SESSION RATE	TOTAL
FOR OFFICE USE ONLY:		
# OF HOURS PAID	**DATE PAID**	**BALANCE**

GRAND TOTAL ---------- **$**

THE THERAPIST WHOSE SIGNATURE APPEARS BELOW CERTIFIES THAT EARLY INTERVENTION SERVICES WERE RENDERED FOR THE DURATION SPECIFIED ABOVE AND ARE APPROPRIATELY DOCUMENTED, AS REQUIRED BY AUTISM PROHELP AND NEW YORK STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

THERAPIST'S SIGNATURE: _____

N.Y.S. LICENSE/CERTIFICATE: _____ **DATE:** _____

BY SIGNING THIS INVOICE, I CONFIRM THAT I RECEIVED THE IN SERVICE MATERIALS, INCLUDING THE DOCUMENTATION REQUIREMENTS FOR INVENTIONISTS, WHICH WERE SENT VIA CERTIFIED MAIL. I ALSO CONFIRM THAT I HAVE READ THE INSERVICE MATERIALS AND THE MEMORANDUM CONTAINIG DOCUMENTATION REQUIREMENTS, UNDERSTOOD THEM, HAVE ASKED QUESTIONS WHERE I WAS UNCERTAIN, AND WILL BE ABIDE BY THE PRINCIPLES AND DIRECTIVES CONTAINED THEREIN. IF I HAVE NOT THE INSERVICE MATERIALS AND THE MEMORANDUM CONTAINING THE DOCUMENTATION REQUIREMENTS, I WILL INFORM AUTISM PROHELP IN WRITING THAT I HAVE NOT RECEIVED THEM.

All session notes MUST be received not later than 30 days from date of service.
Sessions received after the billing timeline will NOT be processed for the payment.