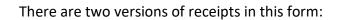
## **RECEIPT FOR THERAPEUTIC SERVICES**



- Version 1: Receipt for therapists who bill monthly
- Version 2: Receipt for individual sessions

			Date:	
			Invoice #: _	
Therapist/Practice:				
Address:				
Phone/Email:				
License #:				
Received from:			for	professional services
Client:				
Diagnostic Code: (if re			nt)	
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	Length of		nt)	
Date	Length of	f Session	nt)	
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Date	Length of	f Session		

	Date:
	Invoice #:
Therapist/Practice:	
Address:	
Phone:	
License #:	
Received from:	for professional services
Client:	
Amount Paid \$	□ Cash □ Check □ Credit Card
Ву:	
	Date:
	Invoice #
Therapist/Practice:	
Address:	
Phone:	<del></del>
License #:	
Received from:	for professional services
Client:	
Amount Paid \$	□ Cash □ Check □ Credit Card