**Mail to**: 33 Ann Street, Ossining, NY 10562 **email to:** eibilling@weblossomtherapy.com

**Early Intervention Provider Invoice**

**Name**:  **Company Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bi-weekly billing period from:** \_\_\_\_\_\_\_\_\_\_\_\_\_-to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Child’s Name** | **Service Type** | **DATE** | **TIME IN (AM/PM)** | **TIME OUT**  **(AM/PM)** | **TOTAL Hours/Units** | **Rate Per Hour/Unit** | **Total** |
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### **Total Sessions**: \_\_\_\_\_\_\_\_\_\_\_\_ **Rate:** \_\_\_\_\_\_\_\_\_\_\_ **Invoice Total:**