INVOICE

**Provider Name**:

**Address:**

**Phone #:**

**Email Address:**

**Bill To:**  New York Therapy Placement Services

**DATE:**

 **Child Name DOB Date of Eval Amount**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**TOTAL AMOUNT =**