INDEPENDENT CONTRACTOR'S INVOICE

Provider Information

Therapist Name:
Address:

Home Phone:
Cell Phone:
Business Phone:

Services Rendered

Month of Service (mmm-yy):

Service Type (circle one): Special Instruction Speech OT PT Family Training

Student Name	Dates of Service (Check all that apply)																															Sessions			Total Due
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Minutes	Count	Rate	

Therapist Signature: _____ Date: _____

Grand Total
(This sheet)