RECEIPT FOR THERAPEUTIC SERVICES

There are two versions of receipts in this form:

- 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 required for insurance reimbursement) _____

Date	Length of Session
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Total Number of Sessions: _____

Amount Paid: $_____ □ Cash □ Check □ Credit Card

Therapist Signature: _____

Date: _____

Invoice #: _____

Therapist/Practice: _____

Address: _____

Phone: _____

License #: _____

Received from: _____ for professional services

Client: _____

Amount Paid $_____ □ Cash □ Check □ Credit Card

By: _____

Date: _____

Invoice # _____

Therapist/Practice: _____

Address: _____

Phone: _____

License #: _____

Received from: _____ for professional services.

Client: _____

Amount Paid $_____ □ Cash □ Check □ Credit Card

By: _____