

WCSP TREATMENT SERVICE
MONTHLY FEE PAYMENT RECORD

Patient: _____

Therapist: _____

Month/Year: _____

Number of Sessions: _____

Dates of Sessions: _____

Fee Per Session: _____

Charge for Month: _____

Amount of Check: _____ **(must be patient's check or money order, no cash, no candidate's personal checks)**

Outstanding Balance: _____

Accumulated hours to date for this patient: _____

Supervisor: _____

Supervisory hours to date: _____

Supervisor signature: _____

COMMENTS:

PLEASE USE ONLY **ONE** FORM PER MONTH

SUBMIT FORM **MONTHLY** TO: WCSP, Nancy Bobker, 260 Stuyvesant Avenue, Rye, NY 10580

TS Monthly Fee Payment Record 5-08