Therapy Station

Billing Period: From_____ TO_____

	Patient Name / Date>	M	T	W	Thu	F	Sa	Su	M	T	W	Thu	F	Sa	Su	Total
1																
2																
3																
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Fax : (813)814-4520

Please fax time sheet by Sunday.

- θ Enter “o” at top right corner for school.
- θ “A” for absent
- θ “NS” No Show
- θ “W” for Withheld
- θ “C” for Cancel
- θ “H” for Hold
- θ “D/C” Discharge
- θ “CT” Cancelled by therapist
- θ “E” Evalv
- θ “RE” Re-evalv
- θ “FSP” Family support plan

TOTAL

# of Treatments_____

Billable Hours_____

Billable Mileage_____

Expense Reimbursement_____

Office Use Only

Therapist Name:_____ Signature:_____