

A.P.D.
BILLING INFORMATION

Client Information: _____

Client Address: _____

Alternate Provider: _____

Alternate Provider Address: _____

Date Entered: _____

Time Entered: _____

Date Exited: _____

Time Exited: _____

Date Entered: _____

Time Entered: _____

Date Exited: _____

Time Exited: _____

Date Entered: _____

Time Entered: _____

Date Exited: _____

Time Exited: _____

Phone Calls: (If any, please specify date, time and number called)

Other Expenses: (If any, Please specify)

Payment Rate of \$ _____ /Day

A.D.P. Representative Signature

Date

Life Sharing Provider Signature

Date

Payment Approval (P.S.)

Date