

Psychological Services Billing Statement

Provider Name _____ FamLink Provider ID _____
 Provider's Address _____ Provider's Phone _____
 DCYF Caseworker _____ Phone Number _____
 DCYF Office _____ FamLink Case ID _____
 Client's Name _____ Client's Phone Number _____

Services Provided

Service Provided	Number of hours	Amount Billed per hour	Total Due
Psychological Evaluation (Testing with interpretation and report)			\$
Parental Evaluation/Parenting Component (Conducted in addition to a Psychological or Neuro-psychological evaluation)			\$
Professional Consultations with DCYF staff or other authorized parties with report			\$
Service Provided	Number of Units	Amount Billed per Unit	Total Due
Individual psychotherapy with report (1 unit = 30 minutes)			\$
Family group of 2 or more -- Psychotherapy & report WITH client present (1 unit = 30 minutes)			\$
Family group of 2 or more -- Psychotherapy & report WITHOUT client present (1 unit = 30 minutes)			\$
Group Psychotherapy with unrelated individuals (1 unit = 30 minutes) Number of Individuals			\$
Case Related Travel (1 unit = 15 minutes) Number of Individuals			\$

Allowed hours & rates are posted at <https://www.dcyf.wa.gov/sites/default/files/pdf/Fee-PsychologicalServices.pdf> units cannot exceed what DCYF authorized.

Date	Description of Tasks (client interview, written testing, report writing, etc.)	Hours

Include a copy of the signed referral and the final report with this invoice.

Comments

Provider Signature _____ Date _____

Travel Log for

Year

Total Number of Units

Date of Service	Staff Name	Start Time AM/PM	End Time AM/PM	Units 1 <i>units is</i> 15 <i>minutes</i>	From Address	To Address	Purpose of Trip