|  |  |
| --- | --- |
| Client Name: | Date of Service: |
| Time In: | Time Out: |
| The following service(s) were conducted on the above date: (please check one) | |
| **Medicaid T19 OR T21** | **Private Insurance** |
| Tech Direct Service | Tech Direct |
| BSA / RBT Supervision by BCBA or BCaBA (Unbilled but paid out by agency) |  |

**Progress on Goals:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Summary of Service Provided:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Clinician Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Signature and Credentials (NOTE: Must use electronic or written signature, no typing of your name, must list your credentials as well)

**Signature of Caregiver:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(NOTE: Required for Title 21 Medicaid and for Private Insurance patients)