|  |  |
| --- | --- |
| **Client Name:** Enter text. | **Client Date of Birth:** Enter a date. |
| **Provider’s Name:** Enter text. | **Provider’s Company Name:** Enter text. |
| **Service Location:** Choose an item. | **Telehealth Modality** (If Applicable)**:** Choose an item. |
| **ICD-10 Diagnosis** (If Applicable)**:** Enter text. | **Date of Service:** Enter a date. |
| **EI Service:** Choose an item.  | **Provider Verified Insurance:** [ ] \*Providers must notify the SC of any changes |
| **Note Type:** Choose an item. |

**Billing Information:**

|  |  |  |
| --- | --- | --- |
| **Select a Service Code or Type a CPT Code** | **Units** | **Duration** |
| Choose an item.  | Enter text. | **Start Time:** Enter text. **End Time:** Enter text.**Total Duration (Minutes):** Enter text. |

**Session Information:
Any updates from family, subjective notes about client’s demeanor:**

|  |
| --- |
| Enter text. |

**Outcome(s)/session plan:**

|  |
| --- |
| Enter text. |

**Observations/progress toward IFSP goal(s):**

|  |
| --- |
| Enter text. |

**Recommendations/strategies:**

|  |
| --- |
| Enter text. |

 **Provider Signature:** Enter text. **Date:** Enter a date.

**Supervising Staff Signature** (If Applicable)**:** Enter text. **Date:** Enter a date.
**Supervising Staff Printed Name** (If Applicable)**:** Enter text.