

FEE FOR SERVICE VERIFICATION LOG

This form must be completed for each client contact for which you are billing under the Fee for Service Program. Please note signatures are required for each contact to verify that services were delivered.

Child's Name _____ Facility/agency providing services
 DOB _____ Vista Rehab Services
 Parent's Name _____ 185 Green Street, Suite 100
 Address: _____ Woodbridge, NJ 07095
 Tel. # _____ Office: (732) 634-5980
 FAX: (732) 634-9508

Date of Service	Description of Services Rendered	Total Units (Hr/Min)	Verification Signature

I verify that services were provided as described above.

_____ Date: _____