Acadia Care Group LLC Individual Client Billing Document

Provider Name: _____ Client Name: _____ Billing Cycle: _____

Date	Start Time	End Time	Service Type	Total Hours	Approval Initial

Provider Signature _____ Date _____

Responsible Party Signature _____ Date _____

Administration _____ Date _____

Do not initial and/or sign until after services have been provided. By Signing, the provider and responsible party certify the hours of service are correct. Services can only be provided to the individual listed on the authorization form. Company is not responsible to pay for services provided in excess of those authorzied for this individual. Use blue or black ink to sign. Do not use white out and/or cross out information.