Bill Sheet

Period of

Circle Discipline			
RN	LPN	HHA	OT
PT	PTA	MSW	ST

Name____

Group ____

Agency Name ___________________Kaerbearøs Healthcare____________________________________

Circle Date of Treatment

Patient Name: Patient ID Number:	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Total Hours/Visits ___________________
Patient Name: Patient ID Number:	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Total Hours/Visits ___________________
Patient Name: Patient ID Number:	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Total Hours/Visits ___________________
Patient Name: Patient ID Number:	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Total Hours/Visits ___________________
Patient Name: Patient ID Number:	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Total Hours/Visits ___________________

Total Hours/Visits___________________ Total for Hours/Visits_____________

Total To Be Paid________________________________