CAPITAL CITY THERAPY GROUP,LLC

720 Old Cherokee Rd. Lexington, SC 29036- Fax: 866-464-4298

PARENT VERIFICATION OF SERVICES

Child Name: _____Provider Name: _____Service Provided:_____

MONTH:

DATE	ARRIVAL	DEPARTURE	PARENT/DATE	THERAPIST/DATE

MONTH:

DATE	ARRIVAL	DEPARTURE	PARENT/DATE	THERAPIST/DATE

MONTH:

DATE	ARRIVAL	DEPARTURE	PARENT/DATE	THERAPIST/DATE