CANADIAN COUNSELLING AND PSYCHOTHERAPY ASSOCIATION

L'ASSOCIATION CANADIENNE DE COUNSELING ET DE PSYCHOTHÉRAPIE

Receipt #:

Date of Payment:

Clinic Information

Name:

Address:

Phone:

Practitioner Name and Designation

Name:

Designation:

Registration #:

Certification #:

HST #:

GST #:

Date	Description of Services	Length of Session (Min.)	Fee	Tax (HST/GST)	Total Amount
	Initial Visit				
	Subsequent Visit				
	Assessment				
	Other (please specify):				

Receipt Issued to:

Name:

☐ Insured

☐ Other _____

Relationship to Insured:

Method of Payment: ☐ Cash ☐ Cheque ☐ Debit ☐ Credit ☐ E-transfer

Duplicate Receipt:

Practitioner's Signature: