Monthly Fee Schedule and Billing Form

Client Name_____

Address_____

_____

Phone#_____ SSN_____

Recovery Specialist_____

	Profession			
	MD/DO DMD/DDS DPM DVM	RPH D.PHARM OD	RN CRNA PA NP CNS CNM RT/RCP ACU AA CHIR PSYC OPT	LPN DH ST AUD CIS LMSW LBSW LISW PT/PTA OT/OTA LPC LMFT LPES PH. TEC D.TEC VET. TEC
Employment Status				
Working in Profession	$50@mo	$40@mo	$25@mo	$15@mo
Working out of Profession	$25@mo	$20@mo	$15@mo	$10@mo
Not Working	$15@mo	$10@mo	$10@mo	$5@mo

I agree to pay the $_____ fee each month according to my Employment Status as a _____(Status)_____(Profession) I am responsible for immediately reporting changes to my current Employment Status to my RPP Recovery Specialist.

Signature_____ Date_____

(Copy retained by client)

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