

Insurance Receipt

Client

Registrant Name

Mailing Address

Date of Birth: DD, Month, YYYY

Date

Date of last session (Session 8)

Provider

Facilitator Name *Credentials*

Insurance Registration Number

Mailing Address

Description	Quantity	Time	Cost
Mindfulness-Based Cognitive Therapy Group therapy program. Skills building and lifestyle counselling for stress, anxiety, and depression management. This program is offered in conjunction with The Centre for Mindfulness Studies. Program Start Date – Program End Date	1	22 hours	\$520
<i>Orientation & Interview – date</i>		2 hours	\$48
<i>Session 1 – date</i>		2.5 hours	\$59
<i>Session 2 – date</i>		2.5 hours	\$59
<i>Session 3 – date</i>		2.5 hours	\$59
<i>Session 4 – date</i>		2.5 hours	\$59
<i>Session 5 – date</i>		2.5 hours	\$59
<i>Session 6 – date</i>		2.5 hours	\$59
<i>Session 7 – date</i>		2.5 hours	\$59
<i>Session 8 – date</i>		2.5 hours	\$59
TOTAL	1	22 hours	\$520

Facilitator Name *Credentials*

Date of signing

Date