EncounterForm NJ

OMNI Health Services Inc
Outpatient Service Encounter Form

Select:	In person Session
Reason for audio only:	Client outside the home
Chart id:	as
Insurance id:	sas
Dob:	asaa
Consumer name:	ssa
Icd 10	asa
Name of the supervising physician:	as
Co pay Amount:	as
Paid Amount:	as
Time in:	as
Time out:	asa
Am or pm:	asa
Insurance carrier:	MA
Smoking History	null
Adult Psychotherapy 21+:	undefined
Adult Psychotherapy 21+:	undefined
Adult Medication Review 21+:	undefined
Child Medication Review 20-:	undefined
Adult Psychiatric Evaluations 21+:	undefined
Child Psychiatric Evaluations 20-:	undefined

I certify that the information shown on this invoice is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements or documents, or concealment of material facts, may be prosecuted under applicable federal and state laws.

Please Sign below, If Agree

Psychiatrist/Psychologist/Therapist Print Name

Client/Guardian/Responsible Party Signature

Supervising Physician Print Name (Medicare Only)
