EncounterForm NJ

OMNI Health Services Inc
Outpatient Service Encounter Form

Select:	null
Reason for audio only:	null
Chart id:	
Insurance id:	
Dob:	
Consumer name:	
Icd 10	
Name of the supervising physician:	
Co pay Amount:	
Paid Amount:	
Time in:	
Time out:	
Am or pm:	
Insurance carrier:	null
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)
