EncounterForm NE BB

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:	
County:	null
Insurance carrier:	null
Assessment done?	null
D/a?	null
In treatment?	null
Referred?	null
Clinician services:	null

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

Therapist Signature 

Therapist Signature

Supervisor Signature
