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:	
City:	null
Insurance carrier:	null
Smoking History	null
Clinician services:	null
Medical 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

Consumer/Parent/Guardian Signature 

Psychiatrist/Psychologist/Therapist Print Name 

Supervising Physician Print Name
(Medicare Only)