EncounterForm NE BB

OMNI Health Services Inc
Outpatient Service Encounter Form

Select:	In person Session
Reason for audio only:	Client outside the home
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:	Lacka
Insurance carrier:	Medicare
Assessment done?	yes
D/a?	no
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

Consumer/Parent/Guardian Signature	
Psychiatrist/Psychologist/Therapist Print Name	
Supervising Physician Print Name (Medicare Only)	