EncounterForm NE BB

OMNI Health Services Inc
Outpatient Service Encounter Form

Select:	In person Session
Reason for audio only:	Client at home
Chart id:	kna
Insurance id:	xankx
Dob:	xaknkn
Consumer name:	ankx
Icd 10	knkwmxk
Name of the supervising physician:	kkscmkm
Co pay Amount:	knckxnk
Paid Amount:	nnqknskn
Time in:	jsknks
Time out:	jnnsajknka
Am or pm:	knkankna
County:	Lacka
Insurance carrier:	MA
Assessment done?	yes
D/a?	yes
In treatment?	yes
Referred?	yes
	90832 Individual Psychotherapy (38-52 Minutes),90837

Clinician services: Individual Psychotherapy (52+ Minutes)

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
