# EncounterForm NE BB

## OMNI Health Services Inc
## Outpatient Service Encounter Form

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|---|---|
| Select: | In person Session,Telehealth only Verbal consent obtained |
| Reason for audio only: | Client at home,Client outside the home |
| Chart id: | aaxa |
| Insurance id: | ax |
| Dob: | 20/03/2000 |
| Consumer name: | xaax |
| Icd 10 | xaxa |
| Name of the supervising physician: | kl |
| Co pay Amount: | aa |
| Paid Amount: | ax |
| Time in: | xaxa |
| Time out: | xaxa |
| Am or pm: | xaxa |
| County: | Lacka,Oyo |
| Insurance carrier: | MA,Self Pay |
| Assessment done? | yes |
| D/a? | yes |
| In treatment? | yes |
| Referred? | yes |
| Clinician services: | 90792 Psychological Evaluation BHRS (Per Evaluation),90837 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**

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Therapist Signature

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Therapist Signature

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Supervisor Signature

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