EncounterForm SE CCBH

OMNI Health Services Inc
Outpatient Service Encounter Form

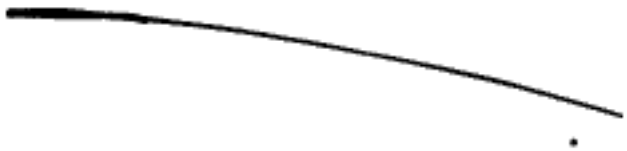
Select:	In person Session
Reason for audio only:	Client at home
Chart id:	
Insurance id:	
Dob:	
Consumer name:	
Icd 10	
Name of the supervising physician:	
Co pay Amount:	
Paid Amount:	
Time in:	
Time out:	
Am or pm:	
County:	Delaware
office:	Chester
Insurance carrier:	MA
Assessment done?	yes
D/a?	yes
In treatment?	yes
Referred?	yes
Clinician services:	90791 Initial Bio-Psychosocial (Max 1.5 hours)

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

Psychiatrist/Psychologist/Therapist Print Name

Client/Guardian/Responsible Party Signature



Supervising Physician Print Name (Medicare Only)
