**TrueNorth Wellness Services**
**Client Encounter / Signature Form**

| Client Name: | Client Date of Birth: | Client MA ID #: |
|---|---|---|
| | | |

I attest to having received these services provided by TrueNorth Wellness Services, Group MA ID# 100744641.

Type(s) of Service Provided *(check all that apply):*

___ Therapy Session ___Evaluation/Assessment
___ Medication Management ___Other Support Service

| Service Date: | Start Time: | End Time: | Client Signature: |
|---|---|---|---|
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The following forms have been reviewed and explained to me:

___ Treatment Plan Signature:_____ Date:____

___ Discharge Summary Signature:_____ Date:____

___ Other:_____ Signature:_____ Date:____

Signatures have been obtained via paper copy due to:

___ Unable to access client portal ___ Office electronic/computer
___ Other: _____ difficulties

I verify that the above mentioned forms were reviewed with me on this date and any questions or concerns were discussed. I understand and am in agreement with the information on the form(s).

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.

Client's Signature: _____ Date: _____

Employee Signature: _____ Date:_____

**Staff: Please scan this form and attach to the service provided on the above date**