CrossWay Counseling Center

1540 Lake Elmo Drive Suite 6 * Billings MT, 59105 * 406-969-5183

Client Information

Last Name First Name Middle Initial Date of Birth

Address City State Zip Code

_____-___-_____ Sex: M ☐ F ☐

SS# Home/Cell/Work Phone #

Primary Insurance Information

Medicaid: ☐ Medicare: ☐ HMK: ☐ Insurance Provider:_____

Member # Group # Insured's Employer Relationship to Client

Insured's Last Name First Name Middle Initial Date of Birth Social Security #

Insured's Address City State Zip Code

Claim's Address City State Zip Insurance Provider's Phone #

Secondary Insurance Information

Medicaid: ☐ Medicare: ☐ HMK: ☐ Insurance Provider:_____

Member # Group # Insured's Employer Relationship to Client

Insured's Last Name First Name Middle Initial Date of Birth Social Security #

Insured's Address City State Zip Code

Claim's Address City State Zip Insurance Provider's Phone #

Emergency Contact Information

Emergency Contact First and Last Name Relationship to Client Phone #

Reminder Information

Email address to receive appointment reminders Cell Phone # to receive text message appointment reminders

I authorize the release of any medical or other information to process this claim. I understand that although insurance may or may not cover part of my charges, I am responsible for payment and I authorize payment of my insurance to be made directly to the provider. By signing below I am giving permission to CrossWay Counseling to send email and/or text message appointment reminders to the address/phone number listed above.

Responsible Party Signature Date