

CW CrossWay Counseling Center

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

Youth Information

Last Name	First Name	Middle Initial	Date of Birth	
Address		City	State	Zip Code
Sex: M <input type="checkbox"/> F <input type="checkbox"/>				
SS#	Youth Home #		/Youth Cell #	

Parent / Guardian Information

Mother / Guardian Last Name	First Name	Middle Initial	Home #	/Cell Phone #
Address		City	State	Zip Code
Father / Guardian Last Name	First Name	Middle Initial	Home #	/Cell Phone #
Address		City	State	Zip Code

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

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

Reminder Information

SMS Reminder's	Email Reminder's
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By providing us with a cell phone number and / or email you are giving us permission to contact you using those methods.

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.

Responsible Party Signature	Date
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