1686 Shiloh Road STE 3
Billings, MT 59106
P: (406) 245-2436 **F:** (406) 281-8805

1540 Lake Elmo Dr. STE 1
Billings, MT 59105
P: (406) 245-2299 **F:** (406) 245-8302

DR. JENNIFER CROSS **DR. STEPHANIE SHOULTS** **DR. DEVIN DESPAIN** **DR. CRYSTAL CARRINGTON-HELLIER**

☐ **I acknowledge and agree that payment is expected at the time of service, including co-payments and co-insurance.**

(PLEASE PRINT)

DATE: _____ FIRST NAME: _____ LAST NAME: _____

BIRTHDATE: _____ NICKNAME: _____

GENDER: ☐ **M** ☐ **F**

AGE: _____ SOCIAL SECURITY NUMBER: _____

EMAIL ADDRESS: _____ PHONE NUMBER: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ ETHNICITY: _____

EMERGENCY CONTACT:

NAME: _____ RELATION: _____ PHONE: _____

INSURANCE:

POLICY HOLDER'S FULL NAME: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

POLICY HOLDER'S DATE OF BIRTH: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
NAME OF INSURANCE

And assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether they're paid by insurance. I hereby authorize the doctor to release all the information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

SIGNATURE OF INSURED/GUARDIAN_____ **DATE:** _____