BEN L. ASHCRAFT, LMFT

1224 South River Road, B-235, St. George UT 84790 • (M) 435.862.8124 • ben.ashcraft77@gmail.com

Contact Information:

Name: ______________________________ Spouse Name: ______________________

Date of Birth: ______________ Social Security Number: # ______________________

Address: ______________________________ City and Zip: ______________________

Home Phone: # ( ) ______________ Work Phone: # ( ) ______________

Mobile Phone: # ( ) ______________ Emergency Contact: ______________________

Email: ______________________________

Referred by: ______________________________

Insurance Information: (person that carries the insurance)

Policy Holder's ID Number: # ______________________

Group Code: ______________________

Policy Holder's Name: ______________________

Policy Holder Date of Birth: ______ /______/________

Employer/Company Name: ______________________

Policy Holder's Contact: (if different from above)

Address: ______________________________ City: ______________ State: ________ Zip: ________

Phone Number: # ( ) ______________ Email: ______________________

Credit Card Information **(if used for payment)**

C.C. Number: ______________________

Zip Code: ________ Exp Date: ________

Email for transaction receipt:

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Insurance Plan Information: **(please provide copy of Insurance Card)**

Insurance Plan: ______________________

Insurance Address: ______________________

City: ______________ State: __________ Zip: ________

Insurance Phone Number: #( ) ______________

Co- pay $____________ Deductible $______________

Is preauthorization required? Yes__________ No __________

Bishop Information **(if responsible for payment)**

Bishop Name: ______________________

Address: ______________________

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Phone #: ______________________

Cell#: ______________________

I authorize Ben L. Ashcraft, LMFT to contact the above insurance or Bishop for the purpose of verifying coverage or billing information and providing appropriate diagnostic information as required for payment. I understand that I am ultimately responsible for payment in the event that the insurance or other billing entity denies the claim or does not make payment. I agree to make payments in full to Ben L. Ashcraft if he is not reimbursed by third party.

Signature(s): ____ Date: ______________________

*Ben L. Ashcraft strongly recommends you contact your insurance about availability of services, co-pays and deductible rates prior to any treatment.
*Missed appointments will be assessed the regular session fee of $100 dollars to the client