

**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: \_\_\_\_\_

**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 \_\_\_\_\_

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

C.C. Number: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Email for transaction receipt:  
\_\_\_\_\_

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

Bishop Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

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 \$95 dollars to the client