Elements of Motivation

Patient Responsibility- Credit/Debit Card on File Agreement

Updated 1.29.2025

It is an Elements of Motivation policy to maintain credit/debit card information securely on file for all clients. In providing us with your credit/debit card information, you are giving permission to Elements of Motivation to automatically charge your credit/debit card on file for your (or any other patient(s) you have listed on this form) copays/coinsurance, outstanding balances, services, and/or products. Payment is due at time of service. Please allow for 10 business days for processing, after which the card on file will be charged.

Copays/Coinsurance: Copays/coinsurances are due upon receipt of the Square invoice. You may still make your payment by mailing/dropping off a check, cash in the office, or using a card different from the credit/debit card on file.

Outstanding Balance: If your insurance provider has paid their portion of your bill (or any other patient(s) you have listed on this form) and there is still an outstanding balance owed, Elements of Motivation will notify you via Square email invoice. If the balance is not paid in full within 5 days of the notice, at that time, any balance owed will be charged to your credit/debit card. A copy of the charge will be emailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Services and Products: Self-Pay services and other fees are due upon receipt of the Square invoice.

This card will only be authorized for the use of the credit/debit card holder or any person(s) listed below by the credit/debit card holder. This agreement will expire upon termination of the services and settlement of final balance. The card holder may also revoke this consent at any time in writing while understanding that continued services may not be available if an unpaid balance accrues. If the credit/debit card given changes, expires, or is denied for any reason, a new, valid credit/debit card will be presented and the new card may be used with the same authorization as the original card.

Please provide your credit/debit card information via one of the following methods:

Visa □ **MasterCard** □ **Discover** □ **American Express** □ **Other** □

Patient's Full Name: _____ DOB: _____

Cardholder's Name (as shown on card): _____

Credit Card Number: _____ Exp. Date: _____

CVV/CVV2 _____ Cardholder Zip Code (from billing address): _____

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Please fill out information below for any other person(s) you authorize this credit/debit card for:

Patient Full Name: _____ DOB: _____

Patient Full Name: _____ DOB: _____

Patient Full Name: _____ DOB: _____

Credit Card Holder's Signature: _____ Date: _____

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Patient Responsibility- Insurance Disclaimer

Insurance Disclaimer: "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures pre authorized by your health insurance company, when applicable. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. We suggest to all patients that they contact their insurance to confirm that these services are covered.

Under this arrangement, you are responsible for paying your copay, any non-covered portions, and any deductible you have yet to cover. In addition, if your insurance company does not pay for our services, you agree to pay for the services provided in our clinic.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Patient's Name, Including Beneficiary's Covered Under this Agreement:

_____

Card Holder's Name: _____

Last Four Digits of Credit Card Number: _____ Exp. Date: _____

Credit Card Holder's Signature: _____ Date: _____

Your copay amount for each session is:_____. This amount is subject to change, according to your insurance coverage. We will make every reasonable and timely effort to inform you of any changes we are made aware of.

Your deductible is _____ and you have _____ remaining.

Elements of Motivation

No Show and Late Cancellation Policy

This policy is intended to help your therapist provide the best care and accommodate all clients efficiently. By outlining expectations for attendance and cancellations, we aim to ensure that appointment times are used effectively and that clients respect the value of both their time and the therapist's time.

Policy Overview

- **No Show:** Failing to attend a scheduled appointment without providing prior notice.
- **Late Cancellation:** Canceling an appointment less than 24 hours before the scheduled time.

Fee

A fee of $90 will be charged for No Shows or Late Cancellations made with less than 24 hours' notice.

Ways to Minimize or Avoid the Fee

- **Cancel Before 24 hours**: Notifications should be made directly to your therapist for fastest receipt. Should you be unable to reach your therapist, please email clinical@elementslv.com or call the office at 702-331-4874.
- **Rescheduling**: If you need to cancel, contact your therapist as soon as possible. Depending on availability, your therapist may be able to reschedule your appointment to another time within the same week to avoid the fee. You may have a three-week window to make arrangements: the week before, during, or after your absence.
- **Telehealth Option:** If you cannot attend an in-person session, ask about the possibility of converting it to a telehealth appointment instead.
- **Communication:** Each therapist may have additional individualized policies regarding missed appointments and cancellations. Discuss with your therapist their specific policies, including how frequently missed appointments may lead to termination of services.

Staying Connected

If you cannot attend a scheduled session, stay in touch by contacting your therapist before the next scheduled appointment to maintain your current schedule.

We value your ongoing commitment to therapy. If we haven't heard from you to reschedule an appointment by the time of your next session, we will check in on your well-being. Your appointment time will never be forfeited due to absences unless we have not heard from you.

Exceptions

We understand that emergencies and unforeseen situations can occur. Exceptions to the No Show fee may be granted in the case of medical emergencies, severe weather conditions, or unforeseen personal emergencies.

Billing and Payment Terms

No Show or late cancellation fee will be invoiced to you via Square.

Unpaid payments for missed sessions will be processed using stored credit card information, as per the client credit card consent form.

Clients will be unable to schedule another appointment until the fee has been paid.

Therapist Policies

Each therapist may have different policies regarding missed appointments and the frequency of No Shows or late cancellations. Some therapists may terminate services after multiple missed appointments in a row or frequent cancellations. Please speak to your individual provider about their specific policy and the possibility of rescheduling to waive the cancellation fee.

Client Acknowledgment

All clients must acknowledge and agree to this policy during their initial intake process. Your acknowledgment indicates understanding and acceptance of the terms outlined in this policy.

Contact for Questions

If you have any questions or concerns about this policy, please contact us at clinical@elementslv.com or call the office at 702-331-4874.

Client/Financially Responsible Person Acknowledgment Form

I, _____, acknowledge that I have read, understand, and agree to the No Show and Late Cancellation Policy as outlined above. I understand that excessive missed sessions may result in the termination of services with Elements of Motivation, and is subject to the discretion of the treating provider.

Client Name: _____DOB:_____

Financially Responsible Person Name (if not Client): _____

Financially Responsible Person Signature: _____Date:_____

Elements of Motivation Representative: _____Date:_____