DC Orthopedics
BETTER CARE BY DESIGN

Patient Financial Agreement & Card on File Authorization

Financial Policy

Dr. Stein and Lauren George, PA do not participate with any insurance carrier or Medicare. The expense for today's visit will be your responsibility.

The estimated cost of today's visit will range from $195 to $595, including any X-rays or ultrasound needed during your visit. Additional services provided beyond a standard visit (such as injections or durable medical equipment) may result in an additional charge.

Cancellation / No-Show Policy

If you do not show up for a scheduled appointment, or if you cancel your appointment within 24 hours of your appointment time, a $150 no-show fee will apply.

Card on File Authorization

I, the undersigned cardholder, hereby authorize DC Orthopedics to charge my credit or debit card ("Card") for all amounts due for services provided by DC Orthopedics to the below patient(s) (each, a "Patient"), and to retain my Card on file for such purpose, in accordance with the following terms:

1. DC Orthopedics may charge my Card for the cost of the Patient's visit, including any additional services described above (such as injections or durable medical equipment), unless another acceptable form of payment is provided at the time of service.
2. DC Orthopedics may charge my Card for the $150 no-show/late-cancellation fee described above, if applicable.
3. DC Orthopedics will provide me with a receipt for all amounts charged to my Card in accordance with this Agreement.
4. DC Orthopedics will store my Card's account information in accordance with applicable law.
5. This Agreement will be effective from the date of my signature below until my Card expires or this Agreement is terminated by me in writing to DC Orthopedics. Termination of this Agreement will not affect my responsibility for any amounts already due to DC Orthopedics for services provided to the Patient(s).

By signing below, I acknowledge that I have read, understand, and agree to the terms of this Patient Financial Agreement and Card on File Authorization.

_____

Patient Name (print)

_____

Cardholder Name, if different from Patient (print)

_____

Signature

_____

Date