

## Credit Card on File Policy

Effective October 2024, Hudson Dermatology allows you the option to keep a credit card on file. We run payments through our electronic health record system, Modernizing Medicine, (ModMed), a HIPAA compliant secure credit card processor. We will store your payment information with your consent on ModMed's secure servers and make it available for future transactions. Our office staff will not have access to your card, only the last four numbers. A valid credit card, debit card, HSA or FSA card will be accepted.

Your credit card on file will be used to pay account balances after insurance adjudication or provide refunds. Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office, showing your total patient responsibility. You typically receive the EOB before we do, so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately.

We will notify you, by email or text, THREE (3) DAYS BEFORE we charge your card. This will allow you the opportunity to call our office if this presents a problem for you or if you need to update your card on file. In addition, a receipt will automatically be sent to your email on file after the payment has been processed.

When using a credit card to pay for medical services, please note there are certain risks, outlined below. Medical bills paid by credit card are no longer considered medical debt, and by paying with a credit card, you forgo specific federal and state protections. These include prohibitions against wage garnishment, property liens, reporting medical debt to credit bureaus, and limitations on interest rates. You must acknowledge and consent to forgoing these protections when opting to pay with a credit card.

### Authorization

I, the undersigned, authorize Hudson Dermatology, PC, to charge my credit card outstanding amounts for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Hudson Dermatology, PC.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 30-day notification in writing, and the account must be in good standing.

Patient Name (print) : \_\_\_\_\_

Patient Signature : \_\_\_\_\_ Date : \_\_\_\_ / \_\_\_\_ / \_\_\_\_