



**ACKNOWLEDGEMENT OF CREDIT CARD RISK FOR
PAYMENT OF MEDICAL SERVICES**

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This form is to inform you of the risks associated with using a credit card to pay for medical services. By signing this form, you affirmatively acknowledge that you have been informed of these risks and consent to proceed with the payment of medical services by credit card.

Each time a credit card is used to pay for medical services, I acknowledge and understand the following risks:

- a. Medical bills paid by credit card are no longer considered medical debt.
- b. By paying with a credit card, I am forgoing federal and state protections around medical debt, including:
 - i. Prohibitions against wage garnishment and property liens.
 - ii. Prohibition against reporting medical debt to credit bureaus.
 - iii. Limitations on interest rates.

Acknowledgment:

I have read and understood the above risks and consent to the use of my credit card for payment.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date/Time

Relationship to Patient

OFFICE USE ONLY:

- Patient is unable to sign due to condition
- Patient refused to sign

Hospital Staff Person's Name

Date & Time