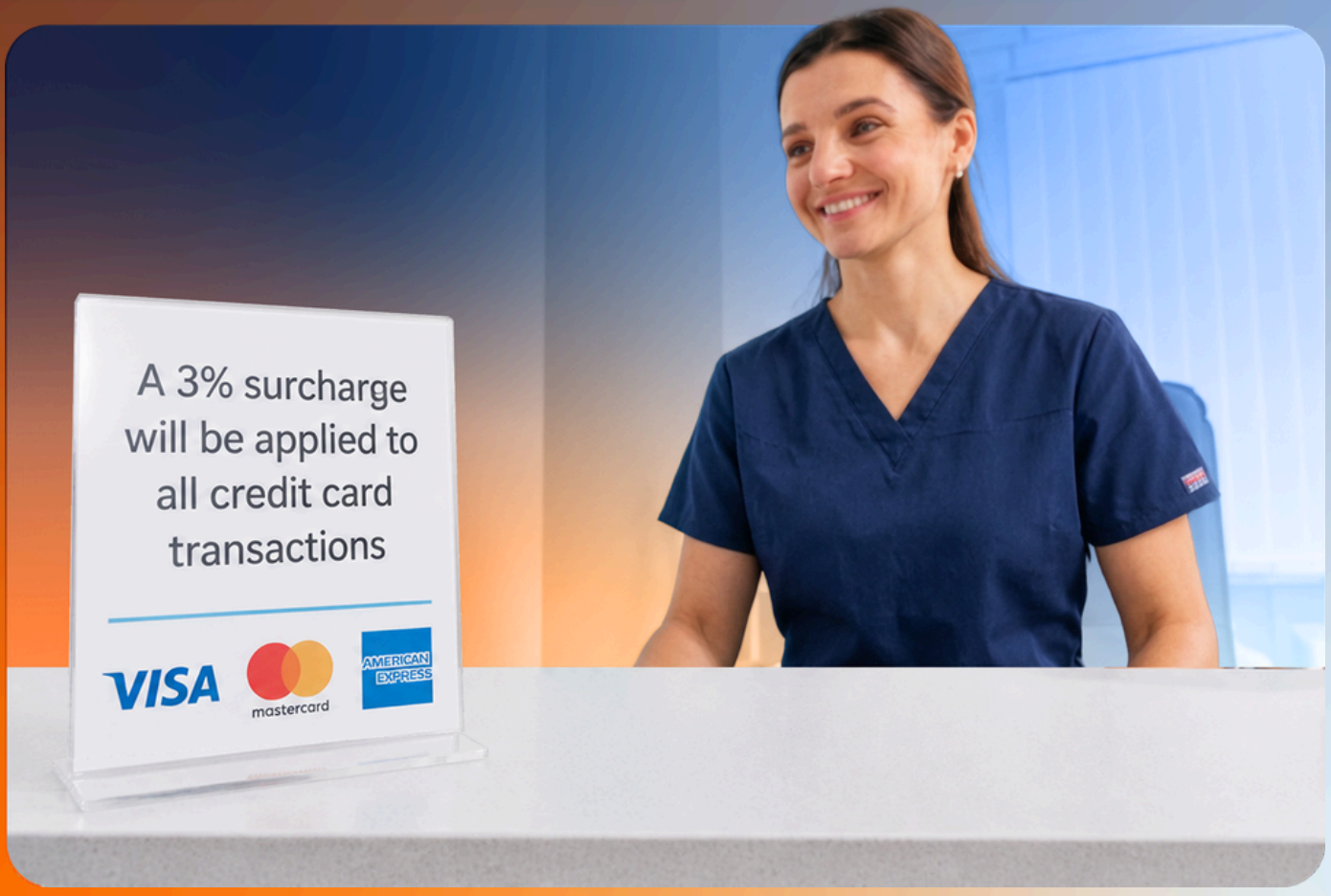
Rectangle HEALTH

GUIDE + CHECKLIST

Healthcare surcharging without surprises

Choosing a vendor that won't cost more than it recovers



GUIDE + CHECKLIST

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SECTION 01

Why surcharging in healthcare is different

Margins are compressed. Practice costs are rising. Card volume keeps climbing. And every dollar of processing cost comes out of the same budget that pays for staff, supplies, and care.

That's why, in many enterprise and multi-location organizations, the decision to surcharge has already been made. This guide is about the decision that comes next.

For healthcare organizations, surcharging is complicated. It invites risks other industries don't face. There are more rules, more exclusions, and the money moves differently after it's collected.

The question isn't whether surcharging works. It's how it must work in a healthcare organization — and what it costs when a vendor treats healthcare as a vertical it can bolt onto a product built for retail.

Here's what to evaluate.

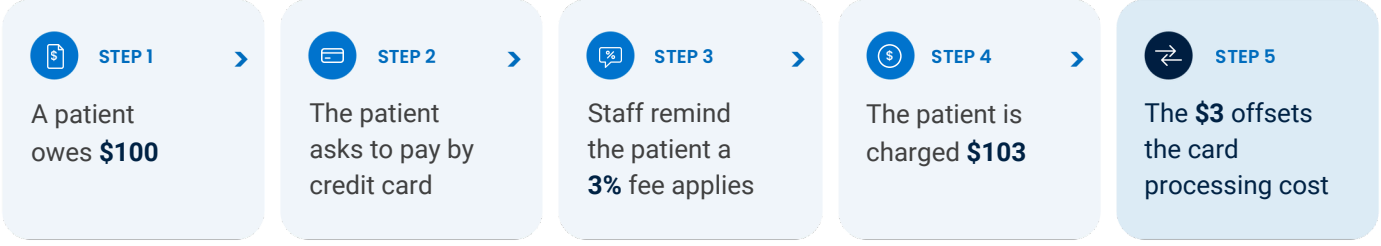
DEFINITION

What is healthcare-compliant surcharging?

Credit card surcharging is a small, clearly disclosed fee added to a credit card transaction to offset the processing cost a provider pays to accept that card.

Healthcare-compliant surcharging is that same mechanism built for the way healthcare organizations actually operate.

How does credit card surcharging work?



Five things make healthcare surcharging different

1 **The exclusions are regulatory, not commercial.**

Debit, prepaid, FSA, and HSA cards can't be surcharged. Neither can copays or services reimbursed by Medicare or Medicaid.

2 **Disclosure requirements are stricter.**

Notice at the point of entry and the point of sale, itemization on the receipt, and clearly communicated payment options that avoid the fee.

3 **Compliance is a moving target.**

State surcharge law and card network rules change independently of each other, and neither sends you a calendar reminder.

4 **Surcharging is rarely standalone.**

It's one function inside a broader approach to collecting from patients and payers, which means it only works if it connects cleanly to the systems each location already has in place.

5 **The setting raises the stakes on execution.**

Staff need signage, receipt language, and a way to offer patients a fee-free payment method at the counter. Vendors often supply all three.

SECTION 02

The stakes: what choosing the wrong vendor actually costs

Surcharging has a ceiling. The cost of getting it wrong doesn't.

At best, a program recovers what you're already paying to accept credit cards, capped by card networks at 3% (sometimes variable by state). That's knowable. The downside hides in five places.

01 Staff time

Manual reconciliation is the most common hidden cost of a surcharging program, and the easiest one to underestimate.

If surcharge dollars land in your operating account alongside patient payments, someone has to separate every deposit, every month, across every location. That responsibility falls to the people already carrying the front desk and the back office.

It also invites the kind of error that's hard to detect and expensive to unwind. Manual processes fail quietly.

02 Financial integrity

When surcharge dollars are accidentally booked as revenue and corrected by hand later, your ledger overstates revenue, your reporting distorts, and your month-end close gets longer. Multi-entity roll-ups compound the problem: every additional location and Merchant ID (MID) adds another place for the correction to be missed.

Tax reporting is affected too. If surcharge dollars are counted as revenue before someone manually backs them out, the 1099-K and the general ledger tell two different stories.

03 Compliance exposure

There's a large audience invested in those small fees. Auditors, your acquiring bank, and card networks reserve the right to scrutinize every surcharge dollar you recover.

If a review finds fees were applied to the wrong card types, in the wrong states, or without adequate disclosure, the exposure isn't limited to the fees themselves.

It extends to the staff members who were supposed to catch it and every transaction that went out before anyone did.

> For healthcare organizations, surcharging is complicated. It invites risks other industries don't face. There are more rules, more exclusions, and the money moves differently after it's collected.

04 Contractual and payer-relationship risk

Providers focused on recovering processing costs can overlook obligations that live in payer contracts and partner agreements — obligations that may restrict when and whether a fee can be applied at all.

It's a failure healthcare enterprises rarely see coming.

The root cause is almost never a platform limitation. It's a configuration decision: the program was never set up to exclude the transaction or payer types it should have excluded.

That's a governance gap, and governance gaps are the ones that surface in an audit or a contract review, not a support ticket.

05 Patient relationships

Patients don't want to pay more. Compliant signage can't change that.

The secret is transparency, training, and timing.

A vendor can supply the signage, the receipt language, and the front-desk script, but the relationship is held by your staff, in the moment the patient asks why the total went up.

These risks are largely avoidable

But only if the program is designed for healthcare from the beginning, rather than adapted to it afterward.

How surcharge enforcement actually works

Card networks rarely contact practices directly. Enforcement runs through your processor.

For example, processors police surcharging through Non-Compliance Assessments, triggered by cardholder complaints and audits, including mystery shoppers. Those assessments land on the acquirer, and nearly every processing agreement passes them through to the merchant.

Fines are the first rung, not the whole ladder.

Escalation can include:

- Per-transaction assessments
- Mandated remediation plans
- Reserve requirements that hold back processing revenue
- Retroactive refunds of improperly collected surcharges (erasing everything the program recovered)
- Termination of card acceptance

The exposure is real enough that processors warn their own sales channels about it. In a memo reported by *Payments Dive*, one processor told its sales partners that merchants out of compliance with Visa's surcharge rules could face fines between **$50,000 and $1 million**.

THE TAKEAWAY

Assessments are complaint-triggered and accrue per transaction. One misconfigured channel doesn't create one violation. It creates one on **every transaction** until someone catches it.

SECTION 03

Follow the money: where surcharge funds land, and why it matters

Many surcharging vendors focus on whether the fee is calculated and disclosed correctly. Ignoring what happens to the money after collection is where solutions break down. There are two approaches — and one costs much more than the other.

COMMON APPROACH

Depositing surcharge funds into your operating account

This is how many surcharging products work, particularly those built for other industries and extended into healthcare.

The surcharge arrives commingled with your revenue. Nothing about this is non-compliant on its face. But it transfers the accounting burden to you — while opening the door to costly human errors.

With this approach, your team owns:

- **Manual reconciliation every cycle.** Pass-through dollars have to be separated from earned revenue after the deposit, not before.
- **A correction history to explain.** Because the two were mixed, the audit trail shows the adjustments you made to unmix them.
- **A ledger that overstates what was owed.** The surcharge posts to the PMS alongside the balance, so the patient record reflects more than the amount billed.

> Nothing about depositing surcharge funds into your operating account is non-compliant. But it transfers the accounting burden to you — while opening the door to costly human errors.

CLEANER APPROACH

Holding surcharge funds separately from operating revenue

A surcharge exists to offset a processing cost. Handling it that way structurally — rather than reconciling and correcting after the fact — removes the busywork and improves accuracy.

With this approach, your organization has:

- **Nothing to reconcile by hand.** The separation happens before the deposit, not after.
- **A cleaner audit trail.** Pass-through dollars and revenue were never mixed, so there's no correction history to explain.
- **Principal-only posting to the PMS.** The patient's balance reflects what they owed, not what they owed plus the fee.

THE RECTANGLE HEALTH APPROACH

Rectangle Health uses this approach: surcharge funds are held separately from the practice's operating account, and the collected amounts are applied against the organization's card processing costs, with monthly reporting that shows the offset.

SECTION 04

What's different in healthcare: the mechanics

A surcharging transaction that's routine in most industries has several ways to break in a healthcare setting.

Which transactions can't be surcharged

The exclusions fall into two groups, and the difference between them is worth understanding before you evaluate anyone.

Exclusions determined by card type

These can be identified and blocked at the moment of the transaction, automatically:

- Debit cards
- Prepaid cards
- FSA and HSA cards

This is why BIN validation matters more in healthcare than anywhere else. Card type isn't something a front-desk team can reliably determine by looking at a card, and these exclusions aren't optional.

Exclusions determined by payer, service, or amount

Copays and services reimbursed by Medicare or Medicaid also can't be surcharged, but nothing in the card itself signals that.

The fix is in the setup: which accounts surcharge, which payment types route where, and which patients are carved out — all decided before the transaction hits the terminal.

That's the part buyers most often skip, because it doesn't look like a feature question, but it's the one that produces the contractual and payer exposure covered above. And the more of it that lives in configuration and training rather than in a staff member's judgment at the counter, the more durable the program.

Make patient transparency part of your culture

Your vendor's job is to make transparency easy: compliant signage, itemized receipts, front-desk scripts, and disclosure language should be supplied, not improvised.

But signage isn't the same as a patient who understands the fee. That part happens inside the practice.

What providers own:

- **Disclose before the point of payment, remind at it.** The fee should surface when the balance is discussed at scheduling, in estimates, and in billing communications, so checkout is a confirmation rather than a surprise.
- **Make sure every staff member can explain the fee in one sentence:** why it exists, how much it is, and how to avoid it. "I don't know, it's just policy" erodes trust faster than the fee does.
- **Present fee-avoidance options as real options.** Debit, HSA/FSA, ACH, and cash should be offered plainly. A patient who chooses the card fee knowingly rarely complains. A patient who discovers it afterward files the complaint that triggers an assessment.
- **Keep the message consistent across every location and channel.** A patient told one thing in the office and shown another online experiences it as bad faith, not as a configuration error.
- **Fold it into onboarding.** Staff turnover is where transparency quietly degrades. The script only works if your newest hire knows it.

> **The compliance link:** card network enforcement is complaint-triggered. A practice culture where no patient is ever surprised by the fee isn't only good patient experience. It's the lowest-cost risk control available.

Disclosure is stricter than in other industries

Patients must be notified of surcharges at the point of entry and the point of sale, the receipt must itemize the surcharge amount separately from the total, and payment options that avoid the fee (debit, ACH, FSA/HSA, or cash) must remain clearly communicated.

Visa's own guidance requires disclosure at both point of entry and point of sale, with itemization on the receipt. A program that's compliant at the terminal and silent at online checkout isn't a partially compliant program. It's a non-compliant one.

Rate caps have to be enforced, not remembered

Under payment card network rules, the surcharge can't exceed 3%. Some states have different rules and requirements. If that's not calculated inside the platform on every transaction for every state you operate in, it's up to staff to get each transaction right.

Signs of a program that's right for healthcare organizations

- BIN lookup that surcharges credit only
- Transaction caps aligned to state regulations
- FSA/HSA detection and blocking
- A rules engine that makes these determinations and reconciles automatically

Surcharging, cash discounting, and convenience fees are not the same thing

The three terms get used interchangeably. They're different mechanisms, with different rules, different operational demands, and different consequences if implemented incorrectly.

Surcharging

A disclosed, capped percentage applied to all credit transactions. Because it scales with transaction size and applies uniformly across channels, nothing has to be repriced.

Cash discounting

The listed price becomes the card price, and cash payers receive a discount. That requires dual pricing everywhere a price is displayed, which fits poorly with most PMS and EHR systems.

Convenience fee

A flat fee attached to a non-standard payment channel only. Because the amount is fixed, it over- or under-recovers depending on transaction size, which rules it out as a primary cost-recovery mechanism.

THE TAKEAWAY

Surcharging is the only one of the three structurally built to scale across full card volume without repricing your services or restricting how patients pay.

How surcharging complexity multiplies for multi-location healthcare organizations

For DSOs and other healthcare organizations, more locations can mean more administrative headaches.

- **Locations can fall under different rules.** Caps, disclosure requirements, and outright prohibitions vary by state. An organization operating across state lines isn't running one surcharging program. It's running several that have to be governed centrally.
- **Staff turnover multiplies the training surface.** Manual rule-keeping doesn't scale past the first few locations, and it degrades fastest exactly where turnover is highest.
- **Payer and virtual card payments have to be handled separately from patient-presented cards.** That's a configuration requirement, not a preference, and a common source of misapplied fees.
- **Technology is fragmented.** Groups that grew through acquisition often run multiple practice management systems. A surcharging program that only posts cleanly into one of them creates manual work in all the others.
- **Financial reporting gets complicated.** Across a multi-entity structure, 1099-K reporting and revenue reconciliation are already difficult. Non-segregated surcharge dollars make them harder.

What good looks like:

Selective enablement by location or state, rules enforced centrally rather than locally, and one reporting view across the organization.

Channel coverage: where the fee applies and where it doesn't

A surcharging program is only as compliant as its least-governed channel.

Not every channel can carry a surcharge. Not every transaction supports surcharging. A card authorized before a surcharging program went live — stored on file, or running on a payment plan — can't carry a fee the patient never agreed to. In that case, surcharging requires reauthorization. That's a legitimate exclusion, not a gap.

What matters is whether the exception is deliberate — routed to a separate merchant account, documented, and consistent with how the fee is disclosed everywhere else — or an unmanaged gap nobody noticed.

That's where the risk sits.

A patient who is never surcharged on a payment plan has nothing to complain about. A patient surcharged in a channel where the fee was never disclosed does, and complaints are what trigger enforcement.

So the question during a vendor evaluation isn't only which channels support surcharging. It's which channels are covered today, which are on a roadmap, and how the platform handles the ones that aren't.

THE ANSWER YOU'LL HEAR

"We support surcharging"

THE ANSWER YOU WANT

"We can tell you exactly where the surcharge does and doesn't apply, and why"

Top surcharging myths, busted

MYTH "All healthcare surcharging solutions are the same."

REALITY Some were designed for other industries and extended into healthcare without accounting for its requirements. The surcharging works, but requires significant manual reconciliation, which makes the program a new competitor for staff time.

MYTH "Once it's disclosed, we're covered."

REALITY Disclosure satisfies the regulatory half. Where the surcharge posts determines how much manual work your team inherits.

MYTH "Compliance is baked into all surcharging solutions."

REALITY Compliant surcharging in healthcare clears three separate bars: state surcharge law, card network rules, and HIPAA. Most platforms are built for the first two. Surprisingly few are built for HIPAA-compliant payments. Because the surcharge is calculated and disclosed inside the same workflow that touches patient and financial data, a platform that doesn't address HIPAA can create PHI exposure that has nothing to do with getting the fee amount right.

MYTH "Patients will push back, or walk."

REALITY Patient resistance is almost always a disclosure problem, not a fee problem. With clear signage, an itemized receipt line, and a heads-up before the card is run, most patients accept the fee as a cost of paying by credit card rather than a hidden markup. They also keep a way to avoid it entirely: debit, ACH, and FSA/HSA payments carry no surcharge. The complaints practices worry about trace back to surprise, not to the fee — which is exactly why compliant disclosure isn't only a legal requirement. It's what makes the program work.

SECTION 05

The three non-negotiables

Here's how to know whether the surcharging solution you're considering truly covers all the bases.

1. Automated

The program shouldn't depend on staff catching requirements the platform should be enforcing.

- **State-specific rules and BIN validation built in** with debit, prepaid, and FSA/HSA blocked automatically rather than flagged for review
- **The 30-day notice requirement to your processing bank** handled as part of implementation, not left as homework
- **Surcharge dollars held separately from operating revenue** so there's nothing for staff to reconcile by hand or explain later
- **Connection with your EMR or PMS** for correct principal-only posting and reporting

2. Cost-neutral

The right technology makes surcharging pay for itself rather than trading a processing cost for an administrative one.

- **Fee calculation automatically held within required limits** determined by payment card networks and the states where you operate
- **Predictable, modeled offset month over month,** visible in reporting rather than reconstructed at close
- **Doesn't create significant hidden costs** of staff administration or reconciliation

Remember: card network rules prohibit profiting on surcharges. A compliant program recovers cost. Any vendor describing surcharging as a revenue stream is describing something else.

3. Scalable

- **Works the same way at 30 locations and 300**
- **Applies consistently across your payment channels** and handles ineligible transactions deliberately, rather than by omission
- **Works across your existing software footprint,** including multiple PMS systems
- **Requires no relearning curve for staff,** so surcharging turns on without rebuilding existing workflows

Use surcharging as an opportunity to consolidate vendors

Every new vendor is another BAA, another audit surface, another login, and another place payment data or PHI can be exposed.

But surcharging doesn't have to expand your third-party risk footprint.

The alternative is one vendor, one relationship, and one audit trail covering surcharging, patient payments, payer payments, and HIPAA compliance.

Rectangle Health delivers all of this in one platform, with surcharging included rather than sold separately.

SECTION 06

Implementation: what good looks like

Implementation is where the difference between a healthcare-built program and an industry-agnostic one becomes clear. What to look for:

- **Setup and channel configuration handled with your team, not handed to it.** Terminal, online, and stored-card configuration is where most compliance gaps originate.
- **Staff training and front-desk scripts provided,** including what to say when a patient asks why the total is higher.
- **Patient-facing disclosure language and signage supplied,** for both physical and digital points of sale.
- **A named relationship manager.** Support representatives who know your configuration is a differentiator, not a footnote — particularly when a state rule changes.

How much could your organization recover?

This calculator makes estimating your potential surcharging cost recovery easy.

For example, an organization processing $350,000 in monthly card volume with an effective recovery rate around 2.5% can recover roughly $68,250 annually.

Estimate your recovery

CHECKLIST

The healthcare-compliant surcharging checklist

Use this during demos, procurement reviews, and leadership discussions. Choosing a surcharging partner is a financial and compliance decision before it's a pricing one.

Vendor name:

Company website / URL:

Primary product(s) evaluated:

Evaluation date:

Evaluator(s):

Department / role(s):

Current vendor (if applicable):

Stage of evaluation: ☑ Initial review ☐ Shortlist ☐ Finalist ☐ Renewal review

Implementation model: ☐ Standalone ☐ Replacing existing ☐ Supports current PMS/EHR

Estimated contract term:

Additional notes/context:

1 Regulatory compliance

If a solution isn't fully compliant, no recovery rate makes it worth the exposure.

WHAT TO LOOK FOR

- [ ] Automated state-specific rule enforcement
- [ ] BIN validation blocking debit, prepaid, FSA, and HSA
- [ ] Built-in handling of the 30-day processor notice
- [ ] Compliant signage for in-person and digital points of sale
- [ ] Patient receipts

WHAT TO ASK

- Is surcharging automatically disabled in restricted or prohibited states?
- How does the platform prevent surcharging debit and FSA/HSA?
- Who is responsible if a rule is violated?

2 Financial and accounting integrity

Where the money goes matters as much as whether it was disclosed.

WHAT TO LOOK FOR

- [ ] Surcharge funds held separately from operating revenue
- [ ] Clear, auditable reporting
- [ ] Correct principal-only posting to the PMS

WHAT TO ASK

- Are surcharge funds deposited into our operating account, or handled separately?
- How would this show up in an audit?
- Does the surcharge ever get counted as revenue?

3 Patient experience and disclosure

The fee should never arrive as a surprise.

WHAT TO LOOK FOR

- [ ] Itemized, disclosed line item on every receipt
- [ ] Point-of-entry and point-of-sale signage
- [ ] Talking points, scripts, and staff guidance
- [ ] Alternative payment options clearly communicated

WHAT TO ASK

- What exactly will patients see on their receipt?
- What options do patients have to avoid the fee?
- What signage and scripts are provided for our front desk?

4 Implementation and scale

You shouldn't have to rip and replace as you grow.

WHAT TO LOOK FOR

- [ ] Multi-location and multi-MID support
- [ ] PMS and EHR connectivity across your footprint
- [ ] Evidence of healthcare compliance — documentation, attestations, or audit artifacts shared with customers

WHAT TO ASK

- Can this be enabled selectively by location or state?
- What's required to implement and maintain it?
- What compliance documentation can you share?

5 Demonstrated outcomes

Experience in healthcare environments, with evidence behind it.

WHAT TO LOOK FOR

- [ ] Documented cost recovery data
- [ ] Verified customer proof of value
- [ ] A healthcare compliance track record

WHAT TO ASK

- Is your surcharging fully healthcare-compliant?
- Can you share documented recovery from a similarly sized healthcare organization?
- How many customers/locations use your surcharging?

SECTION 07

The bottom line: surcharging is a risk decision

Choosing the wrong surcharging partner costs:

Staff time	manual reconciliation instead of automated
Financial integrity	a ledger and reporting distorted by non-segregated fees
Audit exposure	commingled funds that introduce non-compliance risk
Contract compliance	payer and partner obligations missed at configuration
Patient experience	inconsistent disclosure across locations and channels

None of this appears on a pricing sheet, but it surfaces in the first multi-location rollout, the first patient complaint, or the first audit.

Surcharging is a cost-recovery mechanism. Choosing how it's implemented is a risk-management decision.

In healthcare, those are the same decision.

Rectangle HEALTH

NEXT STEP

Start your surcharging evaluation

Rectangle Health pioneered healthcare-compliant surcharging.

Built for healthcare and backed by over 30 years of payments innovation and experience, our platform recovers processing costs without asking your team to manage the difference. **Ready to see what healthcare-compliant surcharging looks like in your organization?**

Book a demo