RUSTAD DERMATOLOGY PC

Troy Rustad MD – Elliott Rustad MD

Financial Policy

Effective February 24, 2015

Please read the following policies, initial by each statement, and sign at the bottom. If you have questions, our billing staff will be glad to discuss these policies with you.

_____ I understand that if I do not have my insurance card and co-payment, that my appointment may be **rescheduled** until such time that I am able provide the required documents and payments.

_____ I understand my insurance plan is a contract between my insurance company and me. Rustad Dermatology PC is not a party to my contract. As a courtesy, Rustad Dermatology PC files all primary and secondary insurance claims on behalf of the patient. Rustad Dermatology PC does not verify in advance a patient's insurance coverage. I understand **it is MY responsibility** to know what provisions, restrictions, and requirements are included or excluded in my health insurance policy.

_____ I understand that the majority of procedures done in the office, no matter how minor, are considered "procedures" or "outpatient **surgery"**, and may have a different benefit, such as requiring a **deductible**, than an **office visit**, which requires a **copayment**. In other words, procedures may be "covered" by my insurance, but not "paid for" until I meet my deductible. I understand I am responsible for payment of all fees, including copayments, and amounts applied to my deductible and surgical co-insurance.

_____ I understand **not all insurance plans cover all dermatology services**. Such non-covered services may include but are not limited to treatment of benign skin lesions, fungal nail infections, hair loss, hyperpigmentation or hypopigmentation, and various cosmetic procedures. I understand **payment for all non-covered services is due at the time of service**.

_____ I understand that in separation or divorce cases, the patient or the parent accompanying the minor to the appointment will be held financially responsible. The divorce decree only involves the divorcees and the State, and we reject any further involvement. I agree to provide permission from the insured party to bill their health care policy.

_____ I understand that Rustad Dermatology PC will bill me for any balance that is a patient responsibility, including but not limited to co-insurance, additional co-payments, and deductible amounts. Patient statements are sent each month. I understand I have 30 days after this statement to pay in full the balance indicated on the statement, unless prior financial arrangements have been approved by our billing manager. **If no payment is received after three (3) statements are sent, your account will be forwarded to our collection department** or a third party collection agency for further action.

_____ I understand that if do not have health insurance, I am responsible for all medical services rendered at Rustad Dermatology PC. Payment in full is due at the time of service.

I have read, understand, and agree to abide by its guidelines the payment policy regarding my financial responsibility to Rustad Dermatology PC for providing medical services to me. I certify that the information I provide to Rustad Dermatology PC is, to the best of knowledge, current, true, and accurate.

_____ _____

Patient or Legal Guardian Signature Date