Dr. Kaurs Office

614 Route 33 E Suite A | EAST WINDSOR NJ, 08520 | (609) 426-9500

Our Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you anytime.

- New patient emergency visits are payable in full when services are rendered
- Patients of record are expected to pay their estimated co-payment at the time of their visit.
- If you have insurance, we will help you receive your maximum benefits. Insurance is a contract between your employer, you and your insurance company. We are NOT a party to this contract. We file insurance claims as a courtesy to our patients. WE WILL NOT become involved in disputes between you and your insurance company regarding deductibles, co-payments covered charges, secondary insurance determination. “Usual & Customary” charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment that will be expected in 15 days. There will be a thirty dollars ($35.00) fee for all returned checks. A processing fee to cover forms mailing and handling expenses will be patient’s responsibility. We DO NOT participate with any HMO, or Medicare. If your insurance company pays more than the balance due, we will send you a refund check upon completion of treatment. By signing below you authorize any necessary signature authorization to expedite the processing of your insurance claims. A late charge of 1.5% (18% per year) is added to unpaid account after 30 days from date service.
- If it becomes necessary to send this account to collection, I agree to pay an added collection fee of 25% of the balance owed or $50.00 minimum.

Please help us to serve you better by keeping scheduled appointments

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED HAVE READ ALL THE INFORMATION AND HAVE COMPLETED THE ABOVE ANSWERS CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE.

Responsible Party’s Signature: _____Date:_____