Carol Paras MD PA :   Practice Policies

Thank you for choosing to seek services in my practice. This is an outline of my general practice policies.

Payment: Payment is expected <u>in full via Zelle</u> on the day of service.

Insurance: Dr. Paras is an out of network provider which means that you personally pay for your visit, on the day of your appointment. You will be provided, monthly, the necessary paperwork to submit your claim to your insurance company, if you have out of network benefits.

Appointments: The time of your appointment is reserved for you. We all have unexpected things that come up and we may occasionally have to make appointment changes at the last minute. That said, missing excessive appointments, can be detrimental to your care. Repetitive missing of appointments will result in termination of care. If I must cancel your appointment, I will make every effort to reschedule within 3 days. Please text any appointment change requests to 845-536-9700.

Maintaining Patient Status: If we decide to work together beyond the initial evaluation, you must be seen on a regular basis. I will inform you of the most efficacious schedule. You will be aware of this **before** you sign the treatment consent.

Termination of treatment;
Treatment can be terminated at will by either party. If I choose to end our working relationship, I must give you 30 days of emergency coverage during which time you should find another provider.
 You, on the other hand, can terminate at will.

 Some reasons that this may occur are personal illness, or other unexpected personal situations, or if you do not or cannot keep follow-up appointments, or if you disagree with what is being recommended, or despite having agreed to a treatment plan, you are not complying with it, or non-payment.

This is a only a partial list of the reasons that treatment may be discontinued.

Please ask any questions you may have before agreeing and signing below.

I_____have fully read these policies and I agree to same.

(Print Full Name)

Signature:_____Date: