Dr. Jessica Holt
920 Frostwood Dr. #670
Houston, TX 77024

Phone: 713-906-7998
Fax: 1-866-594-8432
jbholtmd@gmail.com

PATIENT INFORMATION

Patient Name: _____ Date: _____

Male: _____ Female: _____ SSN: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Do we have your permission to email appointment reminders? YES NO

Pharmacy Name and Phone number: _____

Circle Appropriate:

Minor Single Married Divorced Widowed Separated

Patient's Employer: _____

Occupation: _____ Work Phone: _____

If the patient is a student, name of school/college: _____

Patient's Driver's License #: _____

Spouse or Parent's Name: _____

Spouse or Parent's Employer: _____ Work Phone: _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Driver's License #: _____ Date of Birth: _____

EMERGENCY CONTACT INFORMATION (person to contact in case of an emergency only):

Name & Relation: _____ **Phone:** _____

Name & Relation: _____ **Phone:** _____

Patient *or* Guardian Signature: _____ **Date:** _____

Rev 12/2019

OFFICE POLICY OF JESSICA B. HOLT. M.D., P.A.

The office of Jessica B. Holt, MD, PA welcomes you. I hope that each visit will meet your expectations regarding service, timeliness and courtesy. Please let me know if these expectations are not met.

I will strive to ensure that your appointment begins at the scheduled time; therefore, I ask that all patients arrive on time for their appointments. If you arrive late for your scheduled appointment by 15 minutes or more, *you will not be seen* and will be asked to reschedule your appointment so not to inconvenience other scheduled patients. You will be charged in full for the missed appointment, so please make every effort to arrive on time for your appointment. My practice has adopted the following policies:

1. ***We have a 48 hour cancellation policy, no exceptions***. If you are unable to keep your scheduled appointment, please contact our office at least 48 hours in advance to avoid being charged the full fee of the missed appointment. If you miss your appointment or do not give the proper 48 hour notice of cancellation, a cancellation fee equal to that of the missed appointment will be charged to the credit card on file. ***All fees must be paid prior to scheduling your next appointment.***

2. It is the patient's responsibility to keep track of all upcoming appointments. If time allows, the office will make a courtesy reminder call and/or send an email reminding you of your upcoming appointment, but ultimately it is the patient's responsibility to keep track of all appointments.

3. We recommend that all patients schedule their follow-up appointment immediately following their appointment with the doctor to ensure you do not run out of medication prior to your next scheduled appointment. If you choose to call to schedule your next follow-up appointment, please make sure you call prior to filling your last refill on your medication. ***It is the patient's responsibility to make sure they have an appointment scheduled prior to their medication running out. Medications will not be refilled if you run out of medication prior to your next scheduled appointment.***

4. Any patient receiving a prescription for a controlled substance *must* make an appointment with Dr. Holt at least once every three months (every 90 days). ***Refills will not be given without a required appointment.*** (CII) Controlled substance prescriptions must be filled within 21 days of the earliest fill date noted on the prescription, otherwise the prescription will expire. (Examples of CII meds: Adderall, Adderall XR, Concerta, Mydayis, Ritalin, Vyvanse, etc). Dr. Holt does not e-scribe, she only supplies written paper prescriptions to patients.

5. ***Any lost and/or stolen controlled substance prescription(s) and/or medications must be reported directly to the police department before a new prescription can be issued.*** Once the report is filed, please forward a copy of the police report to us via email, fax or in person, in order to have a replacement issued. ***A replacement controlled substance prescription will not be issued without a copy of the police report for your file. A fee of $15.00 will be charged for replacing a lost, stolen or expired controlled substance prescription.***

6. If a patient requests a prescription to be mailed, a fee equal to that of the shipping charge from FED EX will be charged directly to the patient's credit card on file before the prescription is shipped. A $5.00 handling fee will be attached to each transaction, as well.

7. A written authorization is required to release any information on a client. If we do not have a written authorization on file, we cannot release any information regarding your medical record, including appointment dates/times, receipts/invoices, prescription refills, etc. to spouses, parents, partners, professional assistants, therapists, etc. Authorization forms can be found on our website: www.drjessicaholt.com or can be filled out in our office for your convenience. Release of information can be limited to whatever information you would like to disclose (appointments only, payment information only, complete medical record, medication only, etc.).

8. **If you want to increase, decrease or discontinue your medication, call the office first to discuss before making any changes.** Changes without consent are potentially dangerous and may interfere with our ability to work together. Notification is required.

9. Medication management phone appointments are available to an established patients if:

    1. Patient is stable on their medication regimen
    2. Patient works or attends school outside of the Houston area
    3. Patient cannot reasonably travel to the office during normal business hours.

In-office appointments are preferred, but medication management phone appointments can be arranged if necessary. This type of appointment ***must be scheduled in advance*** and approved by the physician. Patients are limited to a small number of phone appointments per year, and all patients must be seen in the office *at least* one time per year, no exceptions. Please ask Dr. Holt or her manager if you have any questions regarding this type of appointment. A phone appointment is not allowed in all cases, and is approved on a case by case basis.

I have read and understand all the office policies of Jessica B. Holt, MD. I acknowledge and agree with all office policies.

_____ _____

Patient or Guardian's Signature **Date**

_____ _____

Printed Patient Name **Patient's Date of Birth**

Revised 01/2020

Professional Fees

- **Initial Assessment/Consultation** (up to 55 minute appointment): **$400.00**

The first appointment includes gathering patient medical and psychiatric history, arriving at a diagnosis and creating a treatment plan. All patients are asked to complete paperwork prior to their arrival for their appointment. If the paperwork is not complete, it will take away from the time you have with Dr. Holt. Initial visits **must** be paid by credit card or cash. Checks are not an acceptable form of payment for the initial consultation; therefore, will not be accepted. All new patients are required to pay a $100 deposit when scheduling their initial consultation appointment. This $100 will be applied to the balance due for your first visit.

- **Follow-up Appointment and Medication Management** (up to 30 minutes): **$200.00**
- **Brief Medication Management Appointment** (up to 15 minutes): **$100.00**
- **Follow-up Session/Psychotherapy** (up to 55 minutes): **$400.00**
- **Brief Phone Session Medication Management** (up to 15 minutes): **$100.00**
- **Extended Phone Session** (up to 30 minutes): **$200.00**

Fees for Forms/Letters (including but not limited to disability, medical leave, jury duty, etc):

Completion of paperwork for ***medical leave, disability, jury duty, medication distribution, medication cost assistance, etc.***, will incur a minimum fee of $50.00. This fee will increase based on length of the form or letter, and the time it takes to complete. **These fees *are not* included in your appointment fees.**

Simple/Moderate form or letter (0-15 minutes)	**$50.00**
Lengthy form or letter (15-30 minutes)	**$100.00**
Complex form or letter (30 minutes – 60 minutes)	**$200.00**
Emotional Support Animal Letter	**$50.00 per letter**

Medical Records Fee:
Copying/forwarding of medical records/paperwork will incur a *minimum $25.00 fee*. If paperwork is more than 20 pages, additional charges will apply (.50 cents for each additional page along with the cost of delivery of records).

Returned Check Fee: A charge of $35.00 will be applied to your account for any returned checks, which must be paid prior to your next appointment, along with the payment due for the previous appointment that was originally paid by check. We will automatically attempt to charge the credit card on file for this fee if the situation does occur. Checks will not be accepted as a form of payment moving forward.

I have read and understand the entire fee schedule for Dr. Jessica Holt. I acknowledge and agree with Dr. Jessica Holt's office policy and fee schedule.

_____ _____

Patient or Guardian's Signature Date

_____ _____

Printed Patient Name Date of Birth

Dr. Jessica Holt
920 Frostwood, Suite 670
Houston, TX 77024

T: 713-906-7998
F: 866-594-8432
www.drjessicaholt.com

Financial Agreement:

I understand my financial obligations for treatment received from Jessica B. Holt, MD, PA, and agree to pay for any and all services provided. I have read and understand the entire fee schedule for Dr. Holt. I understand that payment is expected at the time of service. I understand if I take additional time with the physician than what was originally scheduled, I will be charged the corresponding fee of the level of service received from the physician.

I understand that I will be charged the full appointment fee for any missed appointments and/or cancellations with less than a 48 hour notice. I understand that I am responsible for all fees associated with this account.

The credit card listed below will be put on file for this purpose. I authorize Jessica B. Holt, MD to charge my credit card listed below for any and all charges associated with my account:

Type of card *(please circle)*: Visa MasterCard AMEX Discover

Credit Card #_____

Expiration Date: _____ Three or Four Digit Security#:_____

Name on the Card:_____

Billing address for the card: _____

_____ _____

Credit Card Holder Name (Printed) **Patient Name (*if different than card holder*)**

_____ _____ _____

Credit Card Holder Signature **Date** **Patient Signature (*if different from cardholder*)**

Revised 01/2020

CONSENT FOR MEDICAL TREATMENT

(Please read the following carefully before signing)

I, the undersigned patient, do hereby voluntarily consent to such treatment involving routine diagnostic procedures and medical treatments as are considered necessary by Jessica B. Holt, MD, and her assistants or her designees. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examination to be rendered.

As stated above, I have voluntarily chosen to receive treatment and I understand that I may terminate treatment at any time. It is recommended you discuss the desire to terminate treatment prior to termination.

I authorize the clinician to carry out psychological testing, evaluation, treatment and/or other diagnostic procedures which now, or during the course of my treatment are reasonable and necessary. I understand that the purpose and goals of these procedures will be fully explained to me at any time upon my request and that they are subject to my agreement and voluntary participation.

I agree to participate fully in my treatment and understand that a lack of commitment on my part to the treatment process may lead to disappointing results and may be grounds for termination of treatment. I understand that experiencing uncomfortable feelings such as anger, frustration, depression and stress are possible side effects of the treatment process. I understand that this can be a normal response to working through life experiences and that these reactions will be worked on as a therapeutic issue if I bring them to the attention of my clinician.

_____ _____

Signature of Patient Date

_____ _____

Signature of Guardian Date
(If patient is a minor or under Guardianship)

_____ _____

Signature of Physician Date

MEDICATION CONSENT

My physician has prescribed the following type(s) of medication for treatment of my mental problems:

- Antidepressant medications
- Stimulants
- Antipsychotic medications (Neuroleptics)
- Anti-cyclic medications (Lithium/anticonvulsants)
- Anti-anxiety medications
- Other

My physician has discussed with me the nature of my mental problems and the reasons why the above medication has been prescribed, including the likelihood of my mental problems improving with medication or not improving without medication.

If effective treatment alternatives to medication are available, my physician has discussed them with me.

It has been explained to me that effective medication may cause side effects in some people, but that most people experience few or no side effects. These side effects have been explained to me and I have been asked to notify staff as soon as possible if I develop any of these side effects.

_____ **(Patient initials) I have been given a copy of a medication instruction sheet explaining these side effects. All the risks, common side effects, and precautions that are listed on the medication instruction sheet were discussed with me and I had the opportunity to ask questions.**

If neuroleptics have been prescribed, my physician has told me that this medication may produce persistent involuntary movements of the face and mouth and at time similar movements of the hands and feet. In certain cases these symptoms may be irreversible and may appear after the medication has been stopped. This side effect is usually associated with taking medication for more than three months and can be minimized by lowering the dosage of the medication and minimizing the use of other medications. It has been explained to me that periodic examination will be conducted to see if such involuntary movements have developed.

I have been given an opportunity to ask any questions regarding my mental problems and the medication treatment.

Based on this explanation, I hereby consent to treatment with the above prescribed medication. I understand that I may withdraw this consent at any time.

_____ _____

Patient/Guardian Signature Date

_____ _____

Physician Signature Date

Patient Consent for Use of Email Communications

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at jbholtmd@gmail.com. Please remember however, that this form of communication is not appropriate for use in an emergency. **Should you require urgent or immediate attention, this medium is not appropriate and should not be used. In an emergency situation, we recommend calling 911 or going to your nearest emergency room.**

When sending an email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that although addressed to me, my staff would have access to this information.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

_____ _____

Patient Signature Date

_____ _____

Witness Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices. I have read and understand the policy and procedures regarding the privacy of health information.

Print Name _____

Signature _____ Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify):

_____

_____

_____

Revised 11/2013

Authorization Form
Release of Information/Medical Records
Dr. Jessica Holt
920 Frostwood, Suite 670
Houston, TX 77024
T: 713-906-7998
F: 866-594-8432

This form when completed and signed by you authorizes Dr. Holt to exchange protected information from your clinical records to, from and/or both, with the person you designate. We will not release any information regarding appointments, treatment, etc., without a release of information on file.

Please circle the type of release that is being authorized and fill out all the information below regarding whom your release applies to (such as a physician, counselor, family member, friend, hospital, facility, etc.)

I authorize Jessica B. Holt, MD to do one of the following:

Release Records to: *OR* **Receive Records from:** *OR* **Release to *and* receive records from:**

Name:_____

Address:_____

City, State:_____ Zip Code:_____

Phone:_____ Fax:_____

This request applies to the following protected health information – check all that apply:

____ **All information**

____ Appointments only

____Billing Reports

____Medication only

____Laboratory Reports

____ Office Notes

____Other – please specify:_____

I am requesting the release of this information for the following reason *(circle one)*:

Transfer of care **Coordination of Care** **Other:** _____

This authorization will remain in effect until patient revokes this authorization in writing by sending written notification to my office address. However, your revocation will not be effective to the extent I have taken action in reliance on the authorization or if this authorization was obtained as a condition of insurance and the insurer has a legal right to contest a claim.

Name of Patient:_____ **DOB:**_____

Name of Guardian (if applicable): _____

Signature: _____ **Date:**_____