DEVELOPMENTAL QUESTIONNAIRE

This questionnaire asks you to respond to a series of questions about you and your family. This type of information is very helpful in making an accurate diagnosis. Please complete these forms as best you can. We will have the opportunity to discuss them in detail at your appointment.

TODAY'S DATE:

NAME	DATE OF BIRTH	AGE
WORK PHONE	**HOME PHONE**	
ADDRESS		
SPOUSE'S NAME	**WORK PHONE**	**CELL PHONE**

Referred by: Phone

Address

Primary Care Physician Phone

Address

Have you notified your physician of this appointment: _____

Have you been seen by any of the professionals listed below for emotional/behavioral problems such as depression, anxiety, etc? Please check and list all that apply:

Psychiatrist _____
Primary Care Physician _____
Therapist _____
Psychologist _____

Please specify the type of treatment received: _____

Why are you seeking professional help at this time:

Outpatient Treatment:

Physician/therapist	Address	Duration of treatment from	to

Inpatient Treatment:

Facility Name	Address	Treating MD	Duration of hospitalization

Medications used that helped: _____

EDUCATIONAL PLACEMENT:

Did you experience any problems in school? _____ No _____ Yes If yes, please describe:

_____

Have you repeated any grades? _____ No _____ Yes If yes, please describe:

_____

Ever in any type of special education class? _____ No _____ Yes If yes, please describe:

_____

Any behavior problems? _____No _____ Yes If yes, please describe:

_____

SOCIAL HISTORY:

Married: ____ No ____ Yes Divorced: ____ No _____ Yes # of marriages _____

Children: ____ No ____ Yes Ages_____ # living with you ____

Do you smoke cigarettes? _____ No _____ Yes

Do you currently use any type of drugs? _____ No _____ Yes If yes, what types of drugs and how much per day? _____

Do you currently drink alcohol? _____ No _____ Yes If yes, what type of alcohol and how much per day?

_____

Any history of legal problems? Please Specify

_____

_____

List any stressful or traumatic events in your life which may have affected your development and ability to function (i.e., birth of sibling, death in the family, divorce, illnesses, frequent school changes, witnessing a trauma).

Incident age comments

_____

_____

_____

_____

_____

MEDICAL HISTORY:

Check all those that apply. In the extra space provided, please describe the condition, and specify the type of treatment received.

Asthma _____
Anemia _____
Seizures _____
Heart Problems _____
Thyroid Problems _____
Glaucoma _____
High Blood Pressure _____
Strokes/Heart Attacks _____

List any other existing or recent medical conditions treated

_____

List Surgeries: Age Complications

_____

_____

List other Hospitalizations Age Reason Length of Stay

_____

_____

List any head injuries Age Loss of consciousness

_____

_____

List any allergies to medications _____

PRESENT MEDICAL STATUS

Current health: ____ poor _____ fair _____ good _____ excellent

Are you in any way physically ill at this time? _____ No _____ Yes, If yes, please explain.

_____

List current medications you are taking. Include dosage and reason. Include vitamin, herbs and over the counter.

_____

_____

Please use this space and any additional sheets for any additional information/comments you wish to share with us about you.

_____

_____

_____

_____

FAMILY PSYCHIATARIC AND MEDICAL HISTORY

Specify which family members suffer from mental health problems or listed medical problems.

	Relationship to patient	Medications (specify)	Hospitalizations
Depression			
Bipolar Disorder			
Anxiety Disorder			
Schizophrenia			
Eating Disorder Anorexia/Bulimia			
Learning Disorder			
Substance Abuse Alcohol/Drugs			
ADHD			
Suicide attempt or Completion			
OCD/Obsessive Compulsive Disorder			
Legal Problems			
Violent Behavior			
Speech Problems			
Tourettes/tic Disorder			
Obesity			
Heart Problems			
High Cholesterol			
Epilepsy/Seizures			
Thyroid Problems			
Other: specify type			

Dr. Jessica Holt
18300 Katy Fwy #315
Houston, TX 77094

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/text appointment reminders? YES NO

Pharmacy Name, Address & 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 12/30/2025

TELEMEDICINE/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.

Telemedicine lets a doctor or other healthcare provider care for you, even when you cannot see her in person. The main goal of telemedicine is to provide you with high quality personal health care even though you are not seeing the provider in person. Providers must follow the same laws for prescribing medication as would at an office visit. You will be talking only to the provider or her staff. Only the provider will hear the session. Likewise, the provider may ask if you are the only one partaking in your session, and may reserve the right to request non- patients (other than legal guardians) to leave the room. Your session may end before all problem are known and treated. It is up to you to follow up for more care if your health problem does not go away. Before your session is scheduled, you will choose the length of time of the appointment and will be told the price associated with the appointment.

During your telemedicine appointment:

- The provider and staff will introduce themselves.
- The provider may talk to you about your health history, exams, x-rays or other tests
- The provider will take notes, and a report of the session will be placed in your doctor's medical record.
- All laws apply about privacy of your healthcare information and medical records apply to telemedicine.

Risks and common problems associated with Telemedicine:

Many patients like telemedicine because they do not have to spend time and money on travel to see a healthcare provider in person. Also, they can see a provider who they might not be able to see otherwise. Technology can make getting health care easy but there can also be some problems.

- If there are equipment or internet problems, then your diagnosis or treatment could be delayed.
- The records sent for review before the session may not be complete. If this happens, then it may be hard for the Telemedicine provider to use his or her best judgment about your health problem. For instance you could react to a drug or have an allergic response if the provider does not have all the information that he or she needs.
- There could be problems with Internet safety (hackers). If this happens, then your medical records may not stay private.
- If there is a technology problem, the information from your session may be lost. This would be outside the control of your doctor.
-

I have read and understand the telemedicine policies of Jessica B. Holt, MD.

_____ _____

Patient or Guardian's Signature **Date**

_____ _____

Patient Printed Name **Date of Birth**

Revised 12/2025

I will make every effort to begin appointments at their scheduled times. To support this, please ensure you are prepared for your appointment. For telephone appointments, have your phone turned on with the ringer volume audible so you do not miss the call. For in-person appointments, please arrive on time.

If I am unable to reach you during your scheduled appointment time, you will be required to reschedule to avoid disrupting subsequent appointments. Missed appointments will be charged in full. This policy applies to all appointment types, including both in-person and telemedicine visits.

My practice has adopted the following policies:

1. We require at least 48 hours' notice for appointment cancellations, with no exceptions. If you are unable to attend your scheduled appointment, please notify our office at least 48 hours in advance to avoid being charged the full appointment fee. Missed appointments or cancellations made with less than 48 hours' notice will incur a fee equal to the cost of the missed appointment, which will be charged to the credit card on file. All outstanding fees must be paid before scheduling your next appointment.

2. Patients are responsible for keeping track of all scheduled appointments. While the office may provide a courtesy reminder via phone call, text message, or email when time permits, responsibility for attending appointments ultimately rests with the patient.

3. Patients are encouraged to schedule their follow-up appointment immediately after their visit with the physician to help prevent interruptions in medication. ***It is the patient's responsibility to ensure an appointment is scheduled before medications run out. Refills will not be provided if medication is exhausted prior to the next scheduled appointment.***

4. Any patient prescribed a controlled substance is required to have an appointment with the physician every 90 days. ***Refills will not be issued without completion of the required appointment.*** Schedule II (CII) controlled substance prescriptions must be filled within 21 days of the earliest fill date indicated on the prescription; prescriptions not filled within this timeframe will expire. All prescriptions are sent electronically to the pharmacy on file after all patient sessions conclude for the day. Pharmacies should expect to receive prescriptions after 5:30 p.m. on the day of the appointment.

5. Any lost or stolen controlled substance medication must be reported to the local police department before a replacement prescription can be issued. After the report is filed, a copy of the police report must be submitted to our office via email or fax. Replacement prescriptions will not be provided without this documentation on file. A replacement fee of $15.00 will apply for any lost, stolen, or expired controlled substance prescription.

6. **Any changes to your medication—including increases, decreases, or discontinuation—must be discussed with the office prior to implementation.** Making changes without prior consultation can be potentially harmful and may interfere with your treatment plan. It is required that you notify the office before adjusting your medication.

7. A written authorization is required for the release of any patient information. Without a signed authorization on file, we are unable to disclose any details from your medical record—including appointment dates and times, receipts or invoices, prescription refills, or other information—to spouses, parents, partners, professional assistants, employers, therapists, or any other third parties. Authorization forms are available on our website at **www.drjessicaholt.com** for your convenience. You may limit the scope of the authorization to specific information you wish to release, such as appointments only, billing information only, medications only, or the complete medical record.

8. Patients are required to update their information whenever changes occur, including but not limited to a new address, phone number, pharmacy, contact details, or release of information preferences. Updated established patient forms, available on our website, must be completed and submitted to our office via email or fax. Maintaining accurate and current information on file is essential for providing timely and effective care.

9. Please be advised that if a patient permanently relocates out of state and no longer maintains a Texas address, we will be unable to continue providing treatment or prescribing medications. This policy does not apply to patients attending college out of state or those temporarily residing outside of Texas due to employment or military obligations, provided a Texas address is maintained.
(Please note that some states do not accept controlled substance prescriptions from physicians who are not licensed in that state. Regulations governing these medications vary by state).

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 12/2025

Professional Fees of Dr. Jessica Holt

The initial appointment includes a comprehensive review of the patient's medical and psychiatric history, formulation of a diagnosis, and development of a treatment plan. All patients are required to complete their required paperwork prior to their appointment.

All paperwork can be found on our website: www.drjessicaholt.com/forms. Completed forms must be emailed or faxed to the office the day prior of the scheduled appointment. This ensures that all paperwork has been received and completed prior to your appointment time. Email: jbholtmd@gmail.com or tracie.drjessicaholt@gmail.com. Our fax number is 1-866-594-8432.

Failure to submit the required paperwork in advance may reduce the time available with Dr. Holt and may prevent the appointment from proceeding. *Established patients are required to update their paperwork annually and email the signed forms to our office.*

Appointment and fees listed below apply to both telemedicine (phone) and in-office appointments. Payment is due 48 hours prior to all appointments. A credit card is kept on file for this purpose.

- **Brief Medication Management Appointment** (up to 15 minutes): **$110.00**
- **Follow-up Appointment and Medication Management** (up to 30 minutes): **$220.00**
- **Follow-up Session/Psychotherapy** (up to 55 minutes)**: $440.00**
- **Initial / New Patient Session** (up to 55 minutes)**: $500**

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 $55.00. 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)	**$55.00**
Lengthy form or letter (15-30 minutes)	**$110.00**
Complex form or letter (31 minutes – 60 minutes)	**$220.00**
Emotional Support Animal Letter	**$60.00 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).

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 _____

Revised 12/2025

Dr. Jessica Holt
18300 Katy Fwy #315
Houston, TX 77094

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

Financial Agreement:

I understand my financial responsibility for all treatment and services provided by Dr. Holt and agree to pay all associated fees. I have read and understand the physician's complete fee schedule. I acknowledge that payment is required at least 48 hours prior to the scheduled service.

I understand that if additional time is spent with the physician beyond what was originally scheduled, I will be charged the applicable fee for the level of service provided.

I understand that I will be charged the full appointment fee for any missed appointments or cancellations made with less than 48 hours' notice. I acknowledge that I am responsible for all fees associated with this account.

I give my permission to charge the 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 12/2025

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

Authorization Form
Release of Information/Medical Records

Dr. Jessica Holt
18300 Katy Fwy #315
Houston, TX 77094
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. *This form is optional – if you do not have anyone to release information to and/or need to get information from, you do not have to fill out this form.*

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:**_____

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):

_____

_____

_____

Notice of Privacy Practices

Effective date: April 15, 2008

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

PURPOSE: This notice tells you how Jessica B. Holt, MD uses and discloses your medical information and your rights regarding your medical information.

APPLICABILITY: Jessica B. Holt, MD, PA and its physicians, psychologists, allied health professionals, and employees follow the privacy practices described in this Notice. Jessica B. Holt, MD, PA keeps your mental and physical health information in records that will be maintained and protected in a confidential manner, as required by law. The individuals identified above will share your health information with each other for purposes of treatment, payment and health care operations that will be described in this Notice.

PROTECTION OF HEALTH CARE INFORMATION AS A PROVIDER OF MENTAL HEALTH SERVICES: The law requires us to protect the privacy of your health information. We will not use or let other people see your health information without your permission except in the ways we tell you in this notice. This protection applies to all heath information we have about you, no matter when you received services. We will not tell anyone you are receiving, or have ever received services from Jessica B. Holt, MD, PA unless the law allows us to disclose that information.
We will ask for your written authorization to use or disclose your health information except for those times when we are allowed to use or disclose this information without your permission, as explained in this notice. In addition, we will ask for your written authorization before releasing your psychotherapy notes. Psychotherapy notes are notes we made about our conversation during a private, group, joint, or family sessions, which we kept in our medical records. If you give us permission to use or disclose your health information and psychotherapy notes, you may revoke it at any time. If you revoke your permission, we will not be liable for using or disclosing your health information and psychotherapy notes before you revoked your permission.
If you are being treated for alcohol or drug abuse, your records are protected by federal law. Violation of these laws that protect alcohol or drug abuse treatment records is a crime and suspected violations may be reported to appropriate authorities in accordance with federal regulations.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Jessica B. Holt, MD, PA may use your protected health information for purposes of providing treatment, obtaining payment for treatment and conducting health care operations.

A. **Treatment**. We may use and disclose your protected health information to a physician and/or other healthcare providers for providing treatment to you. This includes coordination of your care with other health care providers, health plans, referral sources and for continuum of care.

B. **Payment**. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurer to get approval for the treatment that we recommend. In order to get payment for your services, we may also need to disclose your protected health information to your insurance company to demonstrate the medical necessity of the services. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

C. **Operations**. We may use or disclose your protected health information, as necessary, for our own healthcare operations in order to facilitate the function of Jessica B. Holt, MD, PA and to provide quality care to all patients.

USES AND DISCLOSURES THAT ARE PERMITTED AND/OR MANDATORY

Your medical information may be used for the following purposes:

A. **As Required by Law**. We will disclose your protected health information when we are required to do so by any Federal, State or local law. An example would be a request by the Department of Health and Human Services to disclose your information to evaluate our compliance with the privacy regulations.

B. **Public Health Activities**. We may disclose your protected health information to public health agencies for the purpose of preventing, controlling disease, injury or disability; to report vital events such as births or deaths, suspected abuse or neglect, reactions to medications; or to facilitate product recalls.

C. **Health Oversight Activities**. We may disclose your protected health information to a health oversight agency that is authorized by law to conduct health oversight activities including audits, investigations, inspections, licensure and certification surveys. We will not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

D. **Judicial and Administrative Proceedings**. We may disclose your protected health information to courts or administrative agencies that have the authority to hear and resolve lawsuits or disputes. We may disclose your information pursuant to a court order, a subpoena, a discovery request, or other lawful process issued by a judge or other person involved in the dispute. This will only occur after efforts have been made to notify you of the request for disclosure and or to obtain an order protecting your health information.

E. **Law Enforcement Purposes**. We may disclose your protected health information to law enforcement officials in response to a request, as required, to report criminal activity or to respond to a valid subpoena, court order, warrant, summons or similar process.

F. **Coroners, Medical Examiners, Funeral Directors, and for Organ Donation and Tissue Donation**. We may disclose your protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for organ, eye or tissue donation purpose.

G. **Research**. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board or privacy board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

H. **To Avert a Serious Threat to Health or Safety**. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe that such use or disclosure is necessary to prevent or minimize a serious and imminent threat to your health or safety or to the health and safety of the public or another person.

I. **Specified Government Functions**. In certain circumstances, the Federal regulations authorize the provider to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

J. **Worker's Compensation**. The provider may release your health information to comply with worker's compensation laws or similar programs.

K. **Child Abuse**. If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Service, the Texas Youth Commission, or to any local or state law enforcement agency.

L. **Adult and Domestic Abuse**. If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Texas Department of Protective and Regulatory Service.

USES AND DISCLOSURES TO FAMILY AND/OR PERSONAL FRIENDS

We may disclose your protected health information to your family member or a close personal friend if they are involved in your care or who help pay for your care. We may make such disclosures when we have your signed authorization to do so.

YOUR RIGHTS

You have the following rights regarding your health information:

A. **Right to inspect and copy your protected health information**. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that your physician uses for making decisions about you.
We may deny your request to inspect or copy your protected health information if, in our professional judgment, it is determined that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

A licensed psychologists or a psychiatrist who is providing psychological or psychiatric services to an individual is not required to permit the individual to inspect or copy personal records containing protected health information relating to the individual if the information contained in the records has not been disclosed to a person other than another psychologist or psychiatrist for the specific purpose of clinical supervision conducted in the regular course of treatment.
To inspect your medical information, you must submit a written request to Jessica B. Holt, MD, PA. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

B. **Right to request a restriction on uses and disclosures of your protected health information**. You may request limitations on the medical information Jessica B. Holt, MD, PA uses or discloses for treatment, payment, or health care operations, but Jessica B. Holt, MD, PA is not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

C. **Right to confidential communications**. You may request to receive communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.

D. **Right to request amendment**. If you believe that the medical information Jessica B. Holt, MD, PA has about you is incorrect or incomplete, you may request an amendment. On your request, we will discuss the details of the amendment process with you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

E. **Right to an accounting of disclosures**. You may request a list of the disclosures of your medical information that have been made by Jessica B. Holt, MD, PA to persons or entities in the past six years. This right applies to

disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, or certain other disclosures we are permitted to make without your authorization. Accounting requests may not be made for periods of time in excess of six years.

F. **Right to obtain a paper copy of this notice**.

Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

OUR DUTIES

Jessica B. Holt, MD, PA is required by law to maintain the privacy of your health information and to provide you with this Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. If Jessica B. Holt, MD, PA changes its Notice, we will provide a copy of the revised Notice upon request from you.

COMPLAINTS

You have the right to express complaints to Jessica B. Holt, MD, PA and to the United States Department of Health and Human Services, Office of Civil Rights, if you believe that your privacy rights have been violated. You may complain to Jessica B. Holt, MD, PA by contacting the Privacy Official verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be penalized or retaliated against in any way for filing a complaint. You must file your complaint within 180 days of when you knew or should have known about the event that you think violated your privacy rights.

Contact the Privacy officer if:

1. You have a privacy complaint.
2. You have a question about this notice.

Contact the Privacy Official at:

Jessica B. Holt, MD, PA
18300 Katy Fwy #315
Houston, TX 77094
Telephone: (713) 906-7998
Fax: (866) 594-8432
Attention: Privacy Official