Dr. Jessica Holt
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Houston, TX 77094

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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