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
929 Gessner Rd #2225
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, 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 6/30/2022

TELEMEDICINE 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

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 and/or ensure that the ringer on your phone is turned on in order to receive the phone call for your appointments. If you arrive late for your scheduled appointment (late meaning your time scheduled is halfway over or more) or you do not answer your phone, you will be asked to reschedule your appointment so not to inconvenience other scheduled patients. In addition, you will be charged in full for the missed appointment, so please make every effort to arrive on time and/or have your phone ready (with ringer turned on and volume up) 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. ***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). All prescriptions, according to Texas law, must be escribed (electronically sent to your pharmacy). Please be aware that all prescriptions will be sent to the pharmacy at the end of the business day after Dr. Holt finishes with patients for the day. The pharmacy tends to receive the prescriptions between 5:15pm and 6:45pm.

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, or fax, 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. 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.).

7. **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.

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 06/2022

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**

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
929 Gessner Rd, #2225
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 06/2022

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
929 Gessner Rd, # 2225
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):

____

____

____

Revised 2022

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
920 Frostwood, Suite 670
Houston, TX 77024
Telephone: (713) 906-7998
Fax: (866) 594-8432
Attention: Privacy Official