Catherine Holt M.D.
OBSTETRICS/GYNECOLOGY

Providing professional care for your most intimate health needs.

APPOINTMENT POLICY- We value our patients and the time we spend with each of you and we like to set aside appointments that work well for your schedule. If there is a conflict with your appointment time, we ask that you call the office at least 24 business hours in advance to cancel or reschedule. **Appointments cancelled without a 24-business hour advance notice will be charged $40. Ultrasound Appointments cancelled without a 24-business hour advance notice will be charged $50. The same fees will apply for no shows or any rescheduling of an appointment less than 24 business hours.** Any patient who arrives greater than 15 minutes past their scheduled appointment time will be asked to reschedule to a different day. Any patient who no shows three or more times may be dismissed from the practice.

WELL WOMAN EXAMS- Our goal at Catherine Holt MD is to put the patient first by providing outstanding service to each and every patient, each and every visit. In keeping with our policy to educate in the areas of medicine and insurance, we would like to let you know that if you are here for an annual well woman exam, we will only discuss details or perform services applicable to a well woman exam. If there are medical issues that you would like to discuss with Dr. Holt that fall outside of a well woman exam, you will be rescheduled for a problem visit at another date/time. If your problem is emergent, we will address the problem today but will be required to reschedule the annual well woman exam.

If for any reason a problem visit is handled on the same day as an annual visit, the insurance will be billed for each service separately. Depending on your personal insurance benefits, you may be responsible for any out of pocket costs associated with the additional services billed to insurance.

If you have any questions or concerns regarding this policy, please ask our staff.

MEDICAL INSURANCE- Your medical insurance is a benefit that your employer provides for you, or you purchase privately for yourself. Many times, understanding your benefits is confusing. We will do our best to assist you, however, because we are a third party, we have limited access to information regarding your medical benefits. Many plans have specific restrictions and you should consult your insurance handbook for these details.

Regardless of what we may calculate as your medical plan benefit, **you are responsible for the TOTAL cost of your medical treatment.** We will file the claim and do our best to process and coordinate payment from your insurance company.

Please keep in mind that **your insurance company does not guarantee your benefits** therefore we can only estimate your portion. We ask that you pay your estimated portion and deductibles at the time of service. If you are unable to pay this estimated portion today we will be more than happy to reschedule your appointment at a later date.

AFTER HOURS CALLS- We have a physician on-call 7 days a week for **emergencies only**. We appreciate your discretion in using this service as many issues or routine questions can be answered during office hours. **Non-emergent calls handled with a physician will result in a $50 fee.**

RELEASE OF MEDICAL RECORDS- Upon receipt of a signed medical release form, records will be released within 15 days for a $25 fee. Medical records may be transferred to another physician electronically at no charge.

MEDICATION REFILLS- Please allow our office 48 hours for prescription refills. Refills will be processed during our normal business hours.

CONSENT FOR CARE- I hereby consent to necessary examination, procedures and/or treatments prescribed by my physician, his/her assistants, or designee as is necessary in his/her judgment. I understand that I am under the care and supervision of my attending physician.

ACKNOWLEDGEDMENT OF INVESTMENT INTEREST- I understand that Dr. Holt has an investment interest at Baylor Medical Center at Frisco. Dr. Holt is on medical staff at Baylor Medical Center of Frisco as well as other healthcare facilities.

By signing below I acknowledge that I have read and understand the information and policies above.

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Patient name *(printed)* Signature of Patient or Guardian

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Printed name of Guardian Guardian's Relationship to Patient Date