



# Dr. James Webb & Associates

6550 East 71<sup>st</sup> St, Ste 200  
Tulsa, OK 74133  
918.260.9322 Phone  
918.794.8702 Fax

## HIPAA Consent Form / Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov)

### We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**By signing below, I consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

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Signature

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Date Signed

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Printed Name

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Date of Birth



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## NO SHOW / LATE ARRIVAL POLICY

It is our priority to give our patients the time and attention that they deserve, especially during an appointment reserved with Dr. Webb. The goal of this policy is to treat all patients fairly and to give them the time and attention they deserve. We don't like to have policies like this, however, we had to implement this policy after some patients have repetitively abused our time.

**If you arrive more than 15 minutes late for your appointment you may be asked to reschedule.**

### Office Visit Appointments

**A fee of \$50 will be charged to your account if/when:**

- You fail to cancel your appointment within 24 hours of the scheduled time
- You are more than 30 minutes late

This fee is not generally reimbursed by insurance. However, this fee must be paid before we will see you again, regardless of your insurance or our insurance contract(s).

### Pain and Imaging Procedures

A procedure requires additional overhead that is not refundable to our office if a patient cancels or fails to show up. Furthermore, this is a time that another patient could have had a procedure. Please be courteous to our practice and other patients and notify us 24 hours in advance if you need to cancel.

Failure to do so will result in the following:

- You will be charged \$200 for RF Ablations, Kyphoplasty, Vertebroplasty, Discography, and MILD procedures
- You will be charged \$100 for all other procedures.
- If you have failed to cancel and have no showed before, you must pay \$100 before we will schedule another procedure.

This fee must be paid in cash before we will reschedule your appointment.

Cancellations over 24 hours in advance will not incur any fees.

Exceptions will be granted for extenuating circumstances at the sole discretion of Dr. James Webb. Thank you for your cooperation with our office.

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Signature

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Date Signed

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Printed Name

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Date of Birth