

HILLSBOROUGH MEDICAL ASSOCIATES, PA

HARPREET K BAGGA, MD

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**AUTHORIZATION FOR HOUSE CALL VISITS FOR OUR NON PATIENTS OF
OUR PRACTICE**

- 1) I authorize payment of my medical benefits to Hillsborough Medical Associates for services rendered to me.
- 2) I authorize Hillsborough Medical Associates to give my insurance company any information about services rendered to me as necessary to process claims.
- 3) I understand and agree that I am financially responsible for all charges for services rendered to me, including what is not covered by my insurance and balances owed after insurance payments are made.
- 4) I acknowledge that I have read HIPAA Notice of Privacy Practices (NPP) in its entirety and agree to its contents. A copy of the Notice is available on our website
- 5) I also understand and agree to the Trip Service Fees for urgent visits.

Print Patient Name:

Signature of Patient/Guardian/POA

Date
