

## HILLSBOROUGH MEDICAL ASSOCIATES, PA

HARPREET K BAGGA, MD

349 US HWY 206, HILLSBOROUGH, NJ 08844

PHONE: (908) 359-4150 FAX: (908) 359-9548

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### HOUSECALL INFORMATION

Non Patients of our Practice and more than 1 mile radius distance from Primary Office location in Hillsborough, NJ; can also request House call services provided it's within physician's driving route to and from Practice location in Hillsborough, NJ during working and Nonworking hours.

These services are for patients from 3-100 years of age and those who are unable to leave their home or too sick to travel to the doctor or urgent care, and patients wishing to avoid unnecessary ER, or urgent care crowded waiting room visits, and for visitors/travelers to NJ.

**We DONOT provide Emergency Services. If you feel that you or your loved one is having an acute, life threatening medical emergency that requires urgent and immediate care and attention, please call 9-1-1 first.**

House call Medical Services provided are mostly for treatment of urgent or acute medical problem. Our physician also provides comprehensive primary care to patients ages 3-100 and specializes in caring for complex, high risk and high-needs patients. If our physician believes you have a life-threatening medical emergency, they will refer you to the emergency department of your local and nearby hospital.

We accept all Private Insurances and Medicare. We will also bill and file all your insurance claims. Any balance remaining after all insurers pay becomes the patient's responsibility.

In addition, there is also Trip Service Fee of \$75.00 (on weekdays) and \$100.00 (on weekends) for house call visits at patient's private residence seen for urgent visits, which compensates our physician for their travel time.

All Patients must download and fill out **FORMS** and authorize us to treat them before making an appointment and receiving a house call visit. All Forms must be emailed ([hillsbomedical@gmail.com](mailto:hillsbomedical@gmail.com)) or faxed at 908-359-9548 before a house call visit.

Please call our office at 908-359-4150 to request an appointment time for house call visit during working hours. After office hours or weekends/holidays; please follow prompts on the office voice machine. Every attempt will be made to accommodate house call visits on same day or next day.

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**HOUSECALL INFORMATION FOR OUR PATIENTS**

We offer House Call Services for our homebound geriatric patients within 1-2 mile radius distance from our office location in Hillsborough, NJ.

Please call our office at 908-359-4150 to request an appointment time for house call visit during working hours only.

All Patients must download and fill out **FORMS** and authorize us to treat them before making an appointment and receiving a house call visit. All Forms must be emailed ([hillsbomedical@gmail.com](mailto:hillsbomedical@gmail.com)) or faxed at 908-359-9548 before a house call visit.

There is also a Trip Service Fee of \$50.00 for House Call visits at patient's private residence which compensates our physician for their travel time.

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**AUTHORIZATION TO USE AND DISCLOSURE HEALTH INFORMATION**

Patient's Name \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

INFORMATION TO BE RELEASED: *TO* \ *FROM* \_\_\_\_\_

Fax Number: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_

DATES OF TREATMENT: \_\_\_\_\_

TYPE OF INFORMATION TO BE DISCLOSED: (Circle the appropriate)

Office notes    Demographics    Immunizations    Discharge Summary

Consultations    Operative Reports    Lab Reports    Radiology Reports    Entire

Purpose of Disclosure: Medical Care    Insurance    Personal    Legal Matter    Other

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), it may also include information about behavior or mental health services, genetic information, and treatment for alcohol and drug abuse

TERM: This Authorization will remain in effect:

From the date of this Authorization until the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

_____	_____	_____
<b>Signature of Patient</b>	<b>Date</b>	<b>Signature of Witness or Employee</b>

Signature of authorized legal Guardian, Health Care Agent, or other authorized Personal Representative  
\_\_\_\_\_

_____	_____	_____
<b>Relationship</b>	<b>Date</b>	<b>Witness</b>