Dr. Theresa M. Pigott

Holistic Chiropractor
Shamanic Pracatitioner
End-of-Life Doula

Today's Date: _____

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

E-mail Address: _____ Date of Birth: _____ /_____/_____
mm dd yyyy

Male: ☐ Female: ☐ Marital Status: _____ Number of Children: _____

Employer: _____ Employers Address:_____

Work Phone:_____ Can we contact you at work? _____ Occupation: _____

Spouse's Name: _____ Date of Birth: _____ /_____/_____
mm dd yyyy

Spouse's Employer: _____ Address:_____

How did you hear about us? _____

_____ (Initial) A fee of $50 will be charged for missed or cancelled appointment when we do not receive 24 hours' notice.

(Please be sure to read and sign back of form.)

570 Kirts Blvd • Suite 233 • Troy, MI 48084 • **248-822-9253**
www.Authentic-Living-Center.com • drtpigott@hotmail.com

Authorization and Assignment

_____AUTHORIZATION TO RELEASE INFORMATION: I authorize you to release any information you deem appropriate
(Initial) concerning my physical condition to any insurance company, attorney, or adjuster, in order to process any claim for reimbursement of charges incurred by me because of professional services rendered by you, and I hereby release you of any consequences thereof.

_____ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay direct to the
(Initial) Authentic Living Center, any monies due on my account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amount of charges and the amount paid by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim.

_____CONSENT TO CARE FOR MINOR CHILD: I hereby authorize the attending doctor or a designated qualified
(Initial) associate to administer care, as deemed necessary to (name) _____.

Son _____ Daughter_____ Other _____.

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or will be receiving) health care services at the Authentic Living Center. I acknowledge that I have been advised that the doctor providing the services is willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by the insurance proceeds or out of the settlement of a liability case.

I understand that if it is determined either:

a) there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or
b) if a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney;

then payment of services rendered by practitioners at the Authentic Living Center will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

☐ I grant permission to be contacted by Authentic Living Center by email.

☐ I grant permission to be contacted by Authentic Living Center by text.

_____ _____

Signature (Parent or guardian) Date