All Star Pediatrics

Where all of our kids shine!!

Dr. Darlene Eckert, MD
Board Certified Pediatrics

14065 Town Loop Blvd. Suite 300 - Orlando, FL 32837 | Phone: 407-240-5554 | Fax: 407-240-5543

PATIENT REGISTRATION FORM

PLEASE PRINT and COMPLETE ALL SPACES TODAY'S DATE: _____

CHILD'S FULL Legal Name: _____ SS# _____-_____-_____

Nickname (if any): _____ **DATE OF BIRTH** _____ **AGE** _____ **SEX:** ___ **M** or ___ **F**

MOTHER'S (or Legal Guardian) Name: _____Marital Status ___S ___M ___W ___D

ADDRESS: _____ APT#_____ CITY_____

STATE: _____ ZIP: _____ HOME PHONE: _____CELL PHONE:_____

SS # _____-_____-_____ **DATE OF BIRTH:** _____

MOTHER'S PLACE OF EMPLOYMENT:_____

EMPLOYMENT ADDRESS: _____CITY/STATE _____

ZIP _____ WORK PHONE: _____ EXT: _____ POSITION _____

FATHER'S (or Legal Guardian) Name: _____ Marital Status ___S ___M ___W ___D

ADDRESS: _____APT#_____ CITY_____

STATE: _____ZIP: _____HOME PHONE: _____CELL PHONE:_____

SS# _____-_____-_____ **DATE OF BIRTH:** _____

FATHER'S PLACE OF EMPLOYMENT: _____

EMPLOYMENT ADDRESS: _____CITY/STATE_____

ZIP_____ WORK PHONE: _____EXT: _____POSITION _____

CHILD'S MEDICAL INSURANCE POLICY: NAME OF CARRIER _____

INDIVIDUAL_____OR GROUP_____ NAME OF GROUP/EMPLOYER:_____

NAME OF INSURED:_____**POLICY#:**_____

GROUP#: _____ **PHONE # TO VERIFY BENEFITS:** _____

ADDRESS TO MAIL CLAIMS: _____**CITY/STATE:**_____**ZIP**_____

NEAREST RELATIVE (Not Living With Child): _____Relationship:_____

ADDRESS: _____

CITY/STATE/ZIP _____PHONE NUMBER: _____

IF DIVORCED, WHO HAS LEGAL CUSTODY OF THE CHILD? _____MOTHER _____FATHER _____OTHER

UPON REQUEST, WHO MAY OBTAIN MEDICAL INFORMATION ON YOUR CHILD? ____MOTHER ____FATHER _____GRANDPARENT

REFERRED BY: _____

****PAYMENT IS REQUESTED AT THE TIME OF SERVICE. WE ACCEPT CASH AND LOCAL PERSONAL CHECKS PLEASE READ AND SIGN OUR FINANCIAL POLICY CONCERNING THIS MATTER.****

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FINANCIAL POLICY

All Star Pediatrics is committed to providing you and your family with the best possible care. If at anytime you wish to discuss our professional fees, please feel free to ask one of our staff members any questions about our fees, Financial Policy, or your responsibility. Your clear understanding of our Financial Policy is important to our professional relationship.

** All patients must complete our "Patient Information Form", "Medical History Form"and sign our "Financial Policy".
** Payment or CO-Payment is due at TIME OF SERVICE (unless otherwise pre arranged with the Office Manager).
** We accept CASH and LOCAL PERSONAL CHECKS **ONLY.**
** We file to contracted Primary Insurance Carriers only. We **do not** file to secondary carriers.

REGARDING INSURANCE CLAIMS:

If we are contracted with your insurance carrier, we will help you receive maximum benefits. This office files insurance claims for all services rendered at this location, hospitalizations at privilaged hospitals and newborn visits. Laboratory services ***NOT*** performed at All Star Pediatrics will be billed by the laboratory to which the labs were referred. We will make every effort to insure the proper laboratory was used as deemed by your insurance carrier.

We file insurance claims as a **courtesy** to our patients. We will not become involved in disputes between you and your carrier regarding deductibles, copayments, usual and customary charges, etc. other than to supply factual information as necessary upon written authorization from the policy holder.

WALK-INS AND MISSED APPOINTMENTS:

All Star Pediatrics sees patients ***by appointment only.*** Walk-ins are strongly discouraged and will result in a $25 walk-in fee plus the regular office fees. Emergent situations will not be charged, but the doctor will make the final determination.

Please notify our office **at least 24 hours** in advance if you wish to cancel or reschedule an appointment. Our policy is to charge $25 for missed appointments. Repeated NO-SHOWS will result in a dismissal from our practice. Please help us serve you better by keeping your scheduled appointment and arriving on time.

I AUTHORIZE DARLENE ECKERT, M.D. TO RENDER MEDICAL CARE TO MY CHILD, AND ***I UNDERSTAND*** THAT ALL VISITS ARE TO BE PAID AT THE TIME OF SERVICE. IN THE EVENT THAT MY ACCOUNT BECOMES DELINQUENT AND MUST BE TURNED OVER TO AN OUTSIDE COLLECTION AGENCY OR ATTORNEY, ***I AGREE*** TO PAY ANY AND ALL COSTS OF COLLECTION, INCLUDING ATTORNEY'S FEES. IN THE EVENT MY CHILD IS HOSPITALIZED, ***I AUTHORIZE*** THE RELEASE OF ANY MEDICAL INFORMATION,UPON SIGNED, WRITTEN CONSENT, NECESSARY TO PROCESS AN INSURANCE CLAIM OR PROVIDE OTHER COVERED MEDICAL ENTITIES THE NECESSARY INFORMATION TO TREAT MY CHILD. ***I AUTHORIZE*** PAYMENT OF MEDICAL BENEFITS BE MADE DIRECTLY TO ALL STAR PEDIATRICS AND/OR DARLENE ECKERT, M.D.. ***I UNDERSTAND*** THAT MY INSURANCE POLICY IS A CONTRACT BETWEEN MYSELF AND MY INSURANCE COMPANY AND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THE POLICY. ***I WILL ASSIST*** IN THE COLLECTION OF MY INSURANCE BENEFITS SHOULD THERE BE ANY DELAY IN PAYMENT.

TODAY'S DATE: _____
SIGNATURE: _____ PRINTED NAME: _____
RELATIONSHIP TO THE PATIENT: _____