Zimela Wellness Center, LLC

P: 240-362-7077 F:240-362-7161

Welcome to Zimela Wellness Center, LLC. Please call the office or stop by the office to pick up the required forms to be completed before your visit. We ask that you arrive 15 minutes early for your first appointment in order to allow enough time for the registration process.

1. It is our policy **NOT** to prescribe any scheduled medications (such as narcotics and benzodiazepines/ tranquilizers) on the first appointment. We do not prescribe scheduled medications until we have received **ALL** medical documents, in order to consider the best treatment approach for you and our clients.

2. You must also bring your **insurance card, driver's license (or photo ID), and copayment.** If you are unable to provide the necessary information, we will ask that you pay the cash fee.

3. All minors **MUST** be accompanied by a parent or guardian on their first visit. Please bring the minor's immunization record to the first appointment.

4. As a courtesy, we will **file insurance claims** for those insurance plan with which we have an agreement. All co-payments and deductibles are due at the time of service. Please see our Financial, Payment, and Other Policies for further information about our biling guidelines. If we do not participate in your health plan, or if you have no health insurance plan, then cash fees are due at the time of service.

5. **Medication Refills** request needs to be called into the office **7 days before the last dose**. The pharmacy will then in turn contact us for authorization if necessary. Please allow **48 to 72 hours** for any refill authorization. We don't fill medications of the weekend. Please check with the pharmacy to see if they are sent in as we do not call once the refills are sent.

6. We do our best to return all phone calls the same business day. However, calls left after 4pm may not be returned until the following business day. Please leave a working number where you can be reached.

7. After **THREE MISSED APPOINTMENTS** you will automatically be subjected to discharge!

Patient Signature _____Date: _____

Financial, Payment, and Other Polices

Thank you for choosing Zimela Wellness Center, LLC as your behavior health provider. We are committed to providing you with high quality and affordable health care. Please understand that payment for services is necessary for us to continue to provide care to all. The following are our standard Financial, Payment, and other polices. Please read them, ask any questions you may have, and sign in the space provided. We will provide a copy to you upon your request.

1. **Insurance:** We participate in most insurance plans. If you are not insured by a plan we do business with, you must pay in full at each visit. Please note that **WE CAN NOT BILL YOUT INSURANCE COMPANY UNLESS YOU GIVE US YOUR COMPLETE INSURANCE INFORMATION.** We will need an updated insurance card to submit all billing, it is your responsibility with any and all updated information. Patient is required to pay upfront for the visit if not insured or whatever balances remain.

2. **Co-payments and deductibles:** You must pay all co-payments **at time of service.** If you have a high-deductible plan (greater then 500.00 per individual or family), you will be required to pay an estimate of the portion you are responsible for at the time of service.

3. **Non-Covered Services:** Please be aware that some of the services you may receive may be non-covered or not considered reasonable by your insurance company. You must pay for these services in **FULL.**

4. **Proof of Insurance:** All patient information is required to be filled out before seeing the provider. You will need to provider your insurance card and driver's license (or photo ID) and insurance card at your first appointment to be copied. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the claim balance.

5. **Claims Submission:** Will submit all claims and assist you any way reasonably to help get your claims paid. Your insurance company may need you to supply certain information directly. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

6. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate change to help you receive your maximum benefits. If your insurance does not pay your claim within 45 days, the balance will be automatically billed to you.

7. **Non-Payment:** If your account is over 90 days past due you will receive a letter stating that you have 20 days to pay your account in FULL. Partial payments will not be accepted unless otherwise negotiated. Please not that if your balance remains unpaid if will be referred to a collection agency, and you and your immediate family members will be discharged from the practice. There are payment plan options available if needed, ask for application at front desk.

8. **Medical Forms or Letters:** Our policy is to charge $10 in 10 minutes increments required to complete forms.

All patients on routine scheduled medications must agree to the terms of the written medication contract.

I have read and understand Zimela Wellness Center's Financial, Payment and other policies and agree to the above.

Patient Signature: _____

Printed Name: _____

Date: _____

Assignment and Release

I certify that I have insurance coverage and assign directly to Zimela Wellness Center, LLC all insurance benefits. I understand that I am financially responsible for all chargers whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Zimela Wellness Center, LLC may use mu health information and may disclose my information to my insurance company in the purpose of obtaining payments for services.

Patient Signature: _____

Printed Name: _____

Date: _____

Zimela Wellness Center, LLC

Registration Form

Patient Full Name: _____ **Date:**_____

DOB: ___/___/_____ **SSN:** ___-___-____ **Gender:** __M__F **Marital Status:**__S__M__D__W

Address: _____ **City:** _____ **State:**_____ **Zip:**_____

Home Number: _____ **Cell Number:** _____

Email: _____

Would you like to enroll in Patient Portal? ____Y____N

PCP Name: _____ **Phone Numebr:**_____

Preferred Pharmacy: _____ **City:** _____

How did you hear about us? _____

Employer: _____ **Phone:** _____

Employment Status:

____ Active Duty Milliary	____ Full Time
____ Child/ Student	____Part-Time
____ Disabled	____ Homemaker
____ Retired	____ Self Employed
____ Not Employed	____ Other

Insurance Information: Primary

Name of Insurance: _____ Member ID: _____

Subscriber Name: _____ Group #: _____

Subscriber's DOB: _____/_____/_____ SSN: _____/_____/_____

Subscriber relationship to patient: _____

Insurance Information: Secondary

Name of Insurance: _____ Member ID: _____

Subscriber Name: _____ Group #: _____

Subscriber's DOB: _____/_____/_____ SSN: _____/_____/_____

Subscriber relationship to patient: _____

Responsible Party: Check here if self and skip below _____

Name: _____ DOB: ____/____/_____

Address: _____

City: _____ State: _____ Zip:_____

Relationship: _____ Phone: _____-_____-_____

Signature of Patient or Guarantor: _____

Printed Name: _____

Date: _____

HIPPA Release Form

Patient Name: _____ DOB:____/_____/_____

Privacy regulations require us to have a signed release by our patients so we may speak with family members, friends, and other relations regarding your medical treatment and patient financial information. Each person that you wish to be considered a contact must be listed individually by name (including your spouse or significant other).

Please **PRINT** name, relationship and the best telephone number for reach person to whom you are authorizing release of your private health care information.

_____	_____	_____-_____-_____
Name	**Relationship**	**Phone #**
_____	_____	_____-_____-_____
Name	**Relationship**	**Phone #**
_____	_____	_____-_____-_____
Name	**Relationship**	**Phone #**

This authorization will expire in one year from the date it was signed.

_____ _____

Patient Signature Date

Medical Health History

Patient Name:_____ **DOB:** ____-____-_____ **Age:** _____

Current Weight: _____ **Weight 6 Months ago:** _____ **1 Year ago:** _____

Drug Allergies: _____

Medications: (including any over the counter medication and supplements)

Drug **Strength** **Frequency** **Use**

_____

_____

_____

_____

_____

Social History:

Do you or have you ever smoked cigarettes Y or N ___ Packs per Day for ____ years

Did you quit Y or N If so when did you quit? ____ Do you use chew less tobacco? Y or N

Do you drink alcohol? Y or N If so, how much and how often? _____

Do you use illegal drugs/ substance? Y or N If so what? _____

Family History: Please check if anyone in your immediate family has any of the following

Diabetes Y or N and who_____

High Blood Pressure Y or N and who _____

Heart Attack Y or N and who_____

Stroke Y or N and who _____

Mental Health Issues Y or N and who _____

Cancer Y or N and Who _____

Kidney and Liver Issues Y or N _____

Medical History:

Any Surgeries: _____

Do you have any of the following **Medical Problems: Please Circle Apply that apply**

Heart Attack	Y-N	High Cholesterol	Y-N	Seizures	Y-N	Headaches	Y-N
High BP	Y-N	Asthma/ COPD	Y-N	Cancer	Y-N	Joint Pain	Y-N
Diabetes	Y-N	HIV/ AIDS	Y-N	Thyroid Disease	Y-N	Blackouts	Y-N
Stroke	Y-N	GI Issues	Y-N	Hepatitis	Y-N	/ Falling	
Kidney issues	Y-N	Bleeding Disorder	Y-N	Seasonal Allergies	Y-N	Weight issues	Y-N

Patient Signature: _____Date: _____

Symptom Questionnaire

Please use this scale to rate the frequency and severity of symptoms you have experienced over the past two years. If multiple choices are given, please specify what applies in the comment column.

- ☐ Leave the score **blank** if you **Never** have the symptom.
- ☐ Use a **1** if you **Occasionally** have it and the effect is **Mild.**
- ☐ Use a **2** if you **Occasionally** have it and the effect is **Severe.**
- ☐ Use a **3** if you **Frequently or Consistently** have it and the effect is **Mild**
- ☐ Use a **4** if you **Frequently or Consistently** have it and the effect is **Severe.**

Category	Symptom	Score	Comments or Details, if appl.
HEAD	Headache		
	Faintness		
	Dizziness		
	Insomnia		
NOSE	Stuffy nose		
	Sinus problems		
	Hay fever		
	Sneezing attacks		
	Excessive mucus formation		
MOUTH	Chronic coughing		
	Gagging or frequent need to clear throat		
	Sore throat, hoarseness, or loss of voice		
	Swollen or discolored tongue, gums, or lips		
	Chronic tooth or gum pain or jaw pain. Which?		
	Canker sores		
SKIN	Acne		
	Hives or other allergic breakout		
	Rash or persistently dry skin		
	Hair loss		
	Flushing or hot flashes		
	Frequently feel cold		
	Excessive sweating		
	Part of body frequently feeling numb. Which?		
HEART	Irregular or skipped heartbeat		
	Rapid or pounding heartbeat		
	Chest pain		
LUNGS	Chest congestion		
	Asthma, bronchitis		
	Shortness of breath		
	Difficulty breathing		
DIGESTION	Nausea or vomiting		
	Diarrhea		
	Constipation		
	Bloated feeling		
	Belching, burping		
	Passing gas, flatulence		
	Heartburn		
	Intestinal or Stomach pain. Which?		
	Other pain in GI tract? Where?		

Please use this scale to rate the frequency and severity of symptoms you have experienced over the past two years. If multiple choices are given, please specify what applies in the comment column.

- ☐ Leave the score **blank** if you **Never** have the symptom.
- ☐ Use a **1** if you **Occasionally** have it and the effect is **Mild**.
- ☐ Use a **2** if you **Occasionally** have it and the effect is **Severe.**
- ☐ Use a **3** if you **Frequently or Consistently** have it and the effect is **Mild**
- ☐ Use a **4** if you **Frequently or Consistently** have it and the effect is **Severe**.

Category	Symptom	Score	Comments or Details, if appl.
JOINTS AND MUSCLES	Pain or aches in joints		
	Arthritis		
	Stiffness or limitation of movement		
	Pain or aches in muscles		
	Tremor or restless leg		
	Feeling of weakness or tiredness		
WEIGHT	Binge eating/drinking		
	Craving certain foods		
	Excessive weight		
	Compulsive eating		
	Water retention		
	Underweight		
ENERGY	Fatigue, sluggishness		
	Apathy, lethargy		
	Hyperactivity		
	Restlessness		
MIND	Poor memory		
	Confusion, poor comprehension		
	Poor concentration or focus		
	Poor physical coordination		
	Difficulty in making decisions		
	Stuttering or stammering		
	Learning disabilities		
MOOD	Mood swings		
	Anxiety, fear, nervousness		
	Anger, irritability, aggressiveness		
	Depression		
	Other mood challenges?		
OTHER	Frequent illness		
	Frequent or urgent urination		
	Inability to urinate or low urine flow		
	Low libido or other sexual dysfunction		
	Genital itch or discharge		
	Women: Breast fibroids		
	Women: Painful or tender breasts		
	Women: Uterine fibroids		
	Other		
	Other		
	Please tally your scores for this update here:		Total Symptom Score

Any further comments you wish to share?