

MELISSA PARRA, CNP, LLC

www.MelissaParraCNP.com
3901 Georgia Street NE, Suite F
Albuquerque, NM 87110
505-433-4349

Welcome to the office of Melissa Parra, CNP. My goal is to offer you the absolute highest quality of healthcare and medical services by blending the best of Western and Alternative Medicine. I encourage my patients to make health a priority. The patients that benefit most from my care are those who are willing to make changes in their lives; those who allow me to educate and advise them toward a more total integration of physical, emotional and spiritual health.

ABOUT MELISSA PARRA, CFNP

Melissa Parra is a Certified Family Nurse Practitioner with training in Family Medicine, Clinical Herbalism, Dietary Supplements, Nutritional Counseling, and consultation for Hormone Therapy. Traditional therapies and medications are used when appropriate, in addition to providing herbal remedies, nutritional supplements and Bio-Identical hormones. Melissa is a primary care provider; she performs annual wellness and physical exams including gynecological checkups.

PATIENT INFORMATION

During your first visit I will review your complete medical history, address concerns, and order lab tests if necessary. Please bring the new patient forms, recent lab tests or MRIs/X-Rays, a complete list of supplements/medications - including dosages, and a list of any specialists you have seen pertaining to your health concerns with you to your appointment.

FEE SCHEDULE

(Prices do not include tax)

30 minutes \$113

45 minutes \$169

60 minutes \$225

60 minutes (new patients) \$250

\$75 new patient deposit

\$25 body scans

**Body Scan is free with your initial consult. After this it is \$25 for existing patients and \$50 for the general public.*

If your visit extends beyond the times listed above, you will be charged accordingly. The same fees apply for all phone, e-mail or written consultations.

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*Please read the office policy below. **Sign** to indicate that you have read, understand and agree to adhere to my policies. Bring this form to your first appointment.*

FINANCIAL POLICY

All services rendered must be paid in full at time of service. We accept checks, major credit cards and cash. The return check fee is \$35. Payment is due at time of service, a late fee of \$25.00 will be applied to outstanding balances overdue by 30 days or more.

APPOINTMENTS

This is a self-pay office and patients are billed on the amount of time spent with Melissa Parra. This is different from other providers who accept insurance. Insurance companies determine how practitioners charge their patients and this is often the reason for shorter or rushed appointments. My practice is not within the same regulation as many other practitioners and this is why the level of care my patients receive is so much higher.

CANCELLATION POLICY

*There is a **24 hour cancellation policy** for established patients. If you cancel or miss an appointment without 24-hour notice, you will be billed for the visit. **For new patient visits we require 2 business days (48 hours) notice.***

NEW PATIENT DEPOSIT

A \$75 down payment is required for new patients in order to book your first appointment. This is necessary due to last minute cancellations and a long wait list for patients in need of an appointment. The remaining balance for your first visit will be paid at the time services are provided. If you cancel your appointment in accordance with our above cancellation policy, we will refund your \$75. If you miss your appointment you forfeit your down payment. Established patients are not subject to down payments for visits.

INSURANCE

Your medical insurance is a contract between you and your insurance company to which my practice is not a party. My practice does not accept insurance; however, many plans pay a percentage of the visit if you have out of network coverage. I can provide you with a form to file for reimbursement.

MEDICARE/MEDICAID

I am not a Medicare provider; therefore, you cannot bill Medicare for services. Lab work and other tests are generally covered by Medicare if there is medical necessity. Generally HMO Medicare Advantage Plans and Medicaid do not allow a non-participating provider to order labs and diagnostic tests.

WORKERS COMPENSATION

My practice does not accept Workers' Compensation and is not contracted with any insurance company. Check with your insurance carrier as many insurance plans do cover a portion of our fees.

TELEPHONE/EMAIL CONSULTATIONS & INQUIRIES

Any patient who has a brief 2-3 minute question regarding their last appointment, will not be charged. For example, a request for a clarification on a recommendation, medication or supplement qualify as a brief question. This policy applies to all calls, faxes and emails made to office staff. If you have numerous questions or concerns, you may be asked to schedule an appointment. All other questions or inquiries requiring medical expertise will be charged a minimum of \$25, with a possibility of additional charges depending on the amount of time the provider spent on your inquiry. This includes reading emails, letters, composing responses, reports, filling out medical forms, research requests, therapies, etc.

CLINICAL CHARGES

There will be a charge of \$30.00 for all paperwork such as FMLA, Insurance Prior Authorization, New Mexico Cannabis Program, Letter of Medical Necessity etc...along with all laboratory preparations and nursing services.

Melissa Parra CNP is not responsible for any cost of labs or studies ordered on patients. In the event Melissa Parra CNP is billed for any labs or studies ordered, the patient will be fully responsible for repayment of balance due.

Signature _____ Date _____

EMERGENCIES/AFTER HOURS & WEEKEND COVERAGE

My practice is an out-patient practice. I do not see or follow patients in the hospital. Medical problems requiring admission to a hospital will be referred to hospital-based physicians or the physician on call. If a problem arises after normal business hours or on Friday, Saturday, or Sunday and you need medical attention, please go to Urgent Care.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. HIPAA states that there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office medical services.

Your information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, and laboratories.

My practice does not share records electronically, and are not considered a covered entity under HIPPA's requirements. However, it is my policy to keep patient information confidential. Files may be temporarily

left in open racks and will not contain any coding which identifies a patient's condition or information. Patient records will not be available to persons other than office staff.

Melissa Parra's practice agrees to provide patients with access to their records in accordance with state/federal laws. My practice reserves the right to change the terms of this notice and my policies at any time.

Please sign below indicating that you agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

I, _____, hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes in office policy. I understand that my consent remains in force from this time forward.

MEDICAL RECORDS

Melissa Parra's office requires a signed written request from the patient to release medical records. The request can be mailed to 3901 Georgia St. NE Suite F, Albuquerque, NM 87110. Please contact the office for possible fees.

As mandated by the New Mexico Medical Board, all patient files are kept for 10 years. For minors, we keep records 10 years from the age of 21.

*Thank you for reading and understanding the office policy. Please let us know if you have any questions. My intention is to serve the community with the safest and most effective treatments available. **Your personal referrals are greatly appreciated.***

Name (print)_____

Signature_____

Date_____

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Patient Information Forms for MEN

Welcome to Melissa Parra's office. Please fill out your patient history form and bring it with you to your first appointment so that she can review it. This allows her to provide you with the best, most comprehensive care possible. All information is confidential and will only be released with your permission.

Please list the problems you would like addressed and how long you have had them.

What kind of treatments, if any, you have tried?

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Patient Information Sheet

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Age: _____ Date: _____ Sex: (Circle One) **M/F**

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____ Marital Status: _____

Emergency Contact: _____

Race:

Hispanic

African American

Asian

White

Native American

Other

Occupation _____

Primary Physician: _____ Phone: _____ Fax: _____

How did you hear about my practice?

Insurance Information

Name of Insured: _____ Relationship (circle one): Self Spouse Child

Insurance Company: _____ Phone: _____

Policy or ID Number: _____ Group Number: _____

Is this a Worker's Compensation Claim: Y/N

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MEDICARE/MEDICAID OPT OUT CONTRACT

Melissa Parra is **not** a Medicare provider and is exempt from providing Medicare coverage Effective under sections 1128, 1156, or 1892 of the Social Security Act.

By signing this contract, you agree to the following:

As either a patient or as a patient's legal representative, I, _____, accept full responsibility for payment of charges for all services furnished by Melissa Parra CNP.

I understand that Medicare limits do not apply to what Melissa Parra CNP or her staff may charge for items or services furnished by Melissa Parra CNP.

I agree **not** to submit a claim to Medicare or any Medicare Advantage Plan. I will not ask Melissa Parra CNP or her staff to submit a claim to Medicare or any Medicare Advantage Plan.

I understand that Medicare payment will not be made for any items or services furnished by Melissa Parra CNP that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

I understand that I have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare. I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

I also understand that understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

Patient Signature

Date

Patient's Legal Representative (If applicable)

Date

Melissa Parra, CNP

Date

Medicaid Opt out Contract: As either a patient or as a patient's legal representative, I _____, accept full responsibility for payment charges for all services furnished by Melissa Parra CNP. Melissa Parra CNP is not a participating provider with New Mexico Medicaid and does not accept Medicaid as payment for medical services. If I am a patient who is or becomes eligible for New Mexico Medicaid, I understand that I have the right to seek treatment from another provider that accepts New Mexico Medicaid. I or my legal representative agree to be help financially responsible for payment for services rendered by Melissa Parra CNP or her staff.

Physician's Name

Physician's Signature

Date

Patient Signature

Date

Patient's Legal Representative Signature

Date

Witness

Date

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Medication List

List any doctor prescribed MEDICATIONS you are taking, include strength, dosage & frequency of use:

1. _____
2. _____
3. _____
4. _____
5. _____

List any over-the-counter drugs (i.e. Tylenol, Advil), vitamins & herbal supplements. Include strength, dosage & frequency of use:

1. _____
2. _____
3. _____
4. _____
5. _____

List any known drug allergies:

Name _____ Signature _____ Date _____

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Men - Patient History

Urologist of record: _____ Phone _____ Fax _____

Height _____ Weight _____ Change in weight in last year? Y/N Amount? _____ lbs.

Date of last physical exam _____ Date of last digital rectal exam _____

Result: Normal _____ Abnormal _____ Have you ever had a Prostate biopsy? Y/N

Date of last PSA Test _____ Normal _____ Abnormal _____ Value _____

Have you been diagnosed with enlarged prostate? Y/N Date of diagnosis _____

Frequent / Difficult urination: Y/N How many times do you get up at night to urinate? _____

Last Colonoscopy _____ Normal _____ Abnormal _____

Do you snore at night? Y/N Do you have sleep apnea? Y/N CPAP: Y/N

Consider yourself generally Healthy: Y/N Any cardiac events: Y/N Date: _____

Explain: _____

If any lab tests were performed within the last year, please bring these results to the consultation if possible.

From the following, please CIRCLE any past or current medical problems for YOURSELF.

High blood pressure	Blood clots in legs or lungs	Migraine headache
Alcohol/Drug Abuse	Irritable bowel syndrome	Thyroid disorder
Alzheimer's	Prostatitis	Other Cancer
Blood disorders	High Cholesterol	Fibromyalgia
Mental illness, depression	Gallbladder disease/gallstones	Arthritis
Hearing problems	Prostate Cancer	Erectile Dysfunction (ED)
Stroke	Diabetes	Allergies
Chronic fatigue syndrome	Hemorrhoids	Rheumatic fever
Lupus	BPH	Birth defects
Anemia	Kidney disease	Thyroid disease
Seizure disorder	Hepatitis	Emphysema
Skin disorders	Colon Cancer	Epilepsy
Heart disease	Lung disease, asthma, TB	Sexually transmitted disease
Ulcers	Osteoporosis/Osteopenia	Glaucoma
Frequent bladder infections	Breast Cancer	Other _____

Family Medical History

Mother: _____
Father: _____
Siblings: _____
Maternal Grandmother: _____
Maternal Grandfather: _____
Paternal Grandmother: _____
Paternal Grandfather: _____

Surgeries

Year	Nature of Surgery	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you sexually active with: Male(s) _____ Female(s) _____ Both _____ Not sexually active _____

If yes, is sex satisfactory? Y/N

Do you currently use Viagra, Cialis, or Levitra: Y/N Strength: _____

Are you satisfied with the results when using these drugs: Y/N

Do you take nitroglycerin or other nitrate prescription preparations: Y/N

Do you use a penile injection such as Caverject or a Trimix: Y/N

Do you have any sexual, physical or emotional abuse issues you have not had counseling for? Y/N

Have you ever been on hormone therapy? (Testosterone) Y/N If yes, date started: _____

Are you still using hormone therapy: Y/N

What dosage form: Injection _____ Oral _____

Topical _____ Pellets _____ Sublingual _____ Strength: _____ Frequency (daily, weekly etc.) _____

Have you ever been referred to a urologist? Y/N If yes, explain _____

Exercise

Do you consider yourself generally physically fit? Y/N

What type(s) of exercise do you do? _____

How often do you exercise? Daily _____ Weekly _____ Are you trying to lose weight? Y/N

If Yes, how? _____

Do you currently smoke or chew tobacco? Y/N If yes, how many packs per day? _____

Have you ever smoked in the past? Y/N Date started _____ Date Stopped _____

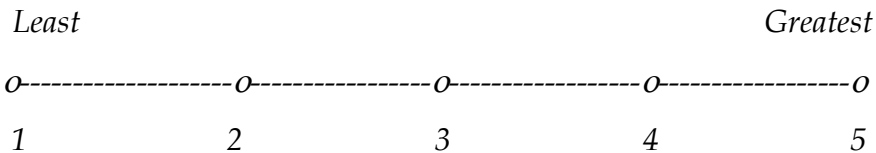
Is alcohol or drug use a problem for you? Y/N If yes, explain: _____

How much Alcohol do you consume daily: _____oz. (hard liquor) _____glass (wine) _____cans of beer

Social drinker: Y/N

Stress

How would you rate your stress level?



How long have you had this amount of stress? Years _____ Months _____

What do you do to relieve stress?: _____

Are you a "care giver": Y/N Explain: _____

Have you had a recent major stress (i.e. loss of job, loss of loved one, change in marital status)? Y/N Explain: _____

Have you been recently diagnosed with any major health issues: Y/N

If yes, explain: _____

Do you have any physical or emotional disabilities: Y/N

If yes, explain: _____

What type of personality are you: Calm _____ Emotional _____ Hyper _____ Worry all the time _____

Are you satisfied with your life: Y/N Are you happy: Y/N Problems sleeping?: Y/N

What mental exercises do you practice to keep your mind sharp?

Is spirituality or religion important in your life? Y/N

Explain: _____

Typical Diet per Day

Please record servings (serving = approximately 4 oz.) for each category of food which has been consumed during a typical day. Also note your mood when you eat and how many ounces of water you drink.

Breakfast	Noon	Dinner	Snack
P _____	P _____	P _____	P _____
C _____	C _____	C _____	C _____
F&V _____	F&V _____	F&V _____	F&V _____

(P = protein C = Carbohydrate F&V = fruits & vegetables)

Mood _____	Mood _____	Mood _____	Mood _____
(G=good, D=depressed, I=indifferent)			

Water (oz.) _____	Water (oz.) _____	Water (oz.) _____	Water (oz.) _____
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Eat fish _____ x per week Eat beef _____ x per week Eat Chicken _____ x per week

Do you have any dietary restrictions/preferences? _____

Do you drink juices such as apple, orange: Y/N Do you juice fruits & vegetables: Y/N

Do you drink carbonated beverages: Y/N How many per day: _____

Do you drink "Diet" beverages: Y/N How many per day _____

How many cups of Coffee or Tea per day: _____ Caffeine _____ Decaf _____

Do you know the difference between a "low" and "high" glycemic index food? Y/N

List food allergies: _____

Review of Systems: Check if you have problems with the following:

____ Chest Pain	____ Indigestion	____ Bleeding Problems
____ Constipation	____ Skin Rashes	____ Fatigue
____ Muscle Pain	____ Anxiety	____ Back Pain
____ Shortness of Breath	____ Gas	____ Memory Problems
____ Diarrhea	____ Acne	____ Leg Swelling
____ Urinating	____ Headaches	____ Joint Pain
____ Aggression	____ Heartburn	____ Insomnia

Other:

If you do not want a hormone consult, skip this page
 SYMPTOM LIST.....IMPROVE YOUR AWARENESS.....FOR MEN

The following symptoms may be associated with hormonal changes. Check and give a relative value to the symptom identified if applicable to start. Symptoms will be reassessed after 30-60 days of therapy.

(S = slight, M = moderate, E = excessive)

<u>TESTOSTERONE</u>	Start	30 days	<u>CORTISOL</u>	Start	30days
↓ Spontaneous early morning erections	_____	_____	Sugar cravings	_____	_____
↓ Libido or desire for sex	_____	_____	Fibromyalgia	_____	_____
Reduced fullness of erections	_____	_____	Aches and pains	_____	_____
↓ Volume of ejaculate	_____	_____	Allergies	_____	_____
Difficulty in maintaining full erection	_____	_____	Inability to handle stress	_____	_____
Difficulty in starting/no erection	_____	_____	Low blood pressure	_____	_____
Mental fatigue, feeling burned out	_____	_____	Salt craving	_____	_____
Sleepiness in afternoon or early evening	_____	_____	<u>THYROID</u>		
↓ in mental sharpness	_____	_____	Morning fatigue	_____	_____
Change in creativity	_____	_____	Hypertension	_____	_____
↓ in initiative or desire to get involved	_____	_____	Nocturnal Cramps	_____	_____
↓ in competitiveness	_____	_____	Morning hoarseness	_____	_____
Memory changes – forgetful	_____	_____	Dry skin	_____	_____
Feeling depressed	_____	_____	Morning stiffness	_____	_____
Joint aches & pains	_____	_____	Low back pain	_____	_____
↓ in flexibility or increased stiffness	_____	_____	Carpel tunnel syndrome	_____	_____
Decrease in muscle size, tone, strength	_____	_____	Sensitive to cold	_____	_____
Decrease in stamina	_____	_____	Poor circulation	_____	_____
Back pain, neck pain	_____	_____	Constipation	_____	_____
Pull muscles or get leg cramps	_____	_____	Puffy face	_____	_____
Development of osteoporosis or arthritis	_____	_____	Partial eyebrows	_____	_____
↑ in total cholesterol or triglycerides	_____	_____	Thin, brittle nails	_____	_____
Decrease in HDL cholesterol	_____	_____	Edema – hands	_____	_____
Rise in blood sugar level or diabetes onset	_____	_____	Low body temperature	_____	_____
Hypertension	_____	_____	<u>GROWTH HORMONE</u>		
Weight gain “beer belly”	_____	_____	Evening fatigue	_____	_____
↑ fat distribution in breast area/hips	_____	_____	Fatty cushions above knee	_____	_____
Diagnosis of heart disease/blockage In arteries	_____	_____	Drooping triceps	_____	_____
Shortness of breath with activities	_____	_____	Sagging cheeks	_____	_____
Light headedness, dizzy spells, ringing in ears	_____	_____	Thin lips/skin	_____	_____
Onset of new headaches	_____	_____	Decreased muscle strength	_____	_____
Changes in visual acuity/focus (fine print)	_____	_____	Light sleep	_____	_____
<u>DHEA</u>			Low self-esteem	_____	_____
Dry eyes	_____	_____	Poor wound healing	_____	_____
Noise sensitivity	_____	_____	<u>MELATONIN</u>		
Excess body odor	_____	_____	Early graying	_____	_____
Light sensitivity	_____	_____	Light anxious sleep	_____	_____