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	***60 minutes (new patients) $250***
45 minutes $169	***$75 new patient deposit***
60 minutes $225	***$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. ***Initial and 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 and major credit cards.* ***We do not accept cash.*** *The return check fee is $35.*

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

_____*I am not a Medicare provider; therefore, you cannot bill Medicare for services. Lab work is generally covered by Medicare if there is medical necessity.*

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.*

*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_____

Parent/Responsible Party Signature _____

Relationship to Patient _____

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Pediatric Information Sheet

Name of Patient: _____ *Sex:* ***M/F*** *DOB:* _____

Parent/Guardian Name: _____ *Relationship to child:* _____

Day Telephone: _____ *Work Telephone:* _____

Emergency Contact: _____ *Phone:* _____

Street Address: _____

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

Email Address: _____

How did you hear about us? _____

Insurance Information

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

Insurance Company: _____ *Phone:* _____

Policy or ID Number: _____ *Group Number:* _____

Medical History

(Circle one)
Has your child ever used homeopathy? ***Y/N***
If yes, what remedies? _____

Has your child ever seen a Naturopathic physician, Chiropractor, Acupuncturist or other alternative healthcare provider? ***Y/N*** *If yes, which/who*_____

Pediatrician/Specialists _____

Are vaccinations up to date? ***Y/N*** *If no, explain:*_____
(If possible provide vaccination schedule)

Any reactions to vaccinations? ***Y/N*** *If yes, explain:* _____

Does your child have food sensitivities? ***Y/N***

If yes, to what foods? _____

Is your child receiving dental care? ***Y/N*** *Date of last exam?* _____

Is/was your child breast fed? ***Y/N*** *For how long?* _____

Is/was your child formula fed? ***Y/N*** *What Brand?* _____

Any known allergies to drugs, animals, herbs or other substances? Please list allergen and reaction:

_____

_____

Does your child now, or in the past, experience (d) the following: (Circle all that apply)

Anemia	*Blood clotting disorder*	*Ear infections*	*Thrush or Candida*
Hepatitis	*HIVor AIDS*	*Blood transfusions*	*Teething difficulties*
Bladder infections	*Chickenpox*	*Thyroid disease*	*Sleep disturbances*
Hernia	*Asthma*	*Hives or Eczema*	*Behavioral issues*
Bleeding tendency	*Epilepsy*	*Gastric reflux (GERD)*	

How would you describe your child's overall health?

(Circle one) *Excellent* *Good* *Average* *Fair* *Poor*

Pregnancy/Delivery History

Was this birth a normal delivery? ***Y/N*** *If not, explain*_____

Duration of pregnancy: _____ *Birth weight:* _____

Any drugs taken during pregnancy? (Include over the counter medications please):

_____

_____

Any alcohol? ***Y/N*** *If yes, how much?* _____

Any tobacco? ***Y/N*** *If yes, how much?* _____

High blood pressure? ***Y/N***

Illness/Infections/Injuries during pregnancy? _____

Delay in respiration or cry? ***Y/N*** *Apgar score, if known?* _____

Was oxygen administration necessary? ***Y/N***

Did your child have any of the following as a newborn? (Circle all that apply)

Jaundice *Cyanosis* *Infection Seizures* *Anemia*

Other important conditions _____

Please list: Illnesses/Injuries and Hospitalizations/Surgeries

1. Age _____ *Reason:* _____

2. Age _____ *Reason:* _____

3. Age _____ *Reason:* _____

Any history of head injury? ***Y/ N*** *If yes, explain:* _____

Has your child ever been unconscious? ***Y/ N*** *If yes, explain:* _____

Has your child ever had seizures? ***Y/ N*** *If yes, explain:* _____

Development

(Write age beside development)

Smile _____ *Pulled to stand* _____

Crawled _____ *First words* _____

Laughed out loud _____ *Walked around furniture*_____

*Walked unassisted*_____ *Sat without support* _____

Completed sentences _____ *Rode bicycle* _____

Rolled over _____ *Toilet trained* _____

First put words together ("bye-bye" or "Daddy") _____

Family History

(Indicate, if known, which family member)

Mental retardation _____ *Cerebral palsy* _____

*Seizures*_____ *Paralysis* _____

*Migraines*_____ *Headaches*_____

Depression/Mental disorders _____ *Any other neurological condition*

Movement disorders _____ _____

School Assessment

(According to parents)

Grade level _____

Reading level _____

*Motivation*_____

*Behavior*_____

Attention _____

Relationship with teachers/peers _____

Achievements _____

_____

Eyesight _____

Hearing _____

*Motor coordination*_____

Speech _____

Any learning problems _____

Miscellaneous

What is the MAIN reason for seeing us today? If there is a specific problem, describe it in detail, including the first time you noticed the condition. List factors you suspect may have played a role in its onset and continuation:

_____

_____

_____

_____

_____

_____

_____

Current Medications (include all over the counter/prescription drugs, name, strength, dosage, and how long he/she has been taking the medication):

_____

_____

_____

_____

Vitamins, herbs or homeopathics (include name, strength, dosage, and how long he/she has been taking the product):

_____

_____

_____

_____