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*_____

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Patient Information Forms for WOMEN

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 OPT OUT CONTRACT

*Melissa Parra is **not** a Medicare provider and is exempt from providing Medicare coverage Effective **July 1, 2018 through July 1, 2020** 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.

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

*I agree **not** to submit a claim to Medicare or to ask Melissa Parra or her staff to submit a claim to Medicare.*

I understand that Medicare payment will not be made for any items or services furnished by Melissa Parra 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) *Relationship*

_____ _____
Melissa Parra, CNP *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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Women - Patient History

Height _____Weight_____ Change in weight in last year? ***Y/N*** *Amount? _____lbs.*

First day of last menstrual period _____ or year of menopause _____

Are you pregnant? ***Y/N***

Date of Last: Pap smear _____ Normal _____ Abnormal _____

Date of Last: Mammogram _____ Normal _____ Abnormal _____

Do you have osteoporosis or osteopenia? ***Y/N*** *Date of diagnosis _____*

Date of last Dexascan:_____Date of 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
Alcohol/Drug Abuse
Alzheimer's
Blood disorders
Mental illness, depression
Hearing problems
Stroke
Chronic fatigue syndrome
Lupus
Anemia
Seizure disorder
Skin disorders
Heart disease
Ulcers
Frequent bladder infections
Blood clots in legs or lungs
Irritable bowel syndrome
Colon Cancer
High Cholesterol
Gallbladder disease/gallstones
Breast Cancer
Diabetes
Hemorrhoids
Ovarian / Cervical cancer
Kidney disease
Hepatitis
Polycystic ovaries (PCOS)
Lung disease, asthma, TB
Osteoporosis/Osteopenia
Uterine Fibroids
Migraine headache
Thyroid disorder
Other Cancer
Fibromyalgia
Arthritis
Allergies
Rheumatic fever
Birth defects
Thyroid disease
Emphysema
Epilepsy
Sexually transmitted disease
Glaucoma
Other_____

Family History

Mother: _____

Father: _____

Siblings: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Surgeries

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

Gynecological History

Are you still having periods? ***Y / N*** *Any spotting/bleeding between periods?* ***Y / N***

Is menstrual pain/cramping a problem for you? ***Y / N*** *Date of last Cycle*_____

Are you presently using birth control? ***Y / N*** *If yes, what type*_____ *How long* _____

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

If yes, is sex satisfactory? ***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: ***Y/N*** *If yes, when:* _____ *Type:*_____

Are you still on hormone Therapy: ***Y/N*** *Satisfied with results:* ***Y/N***

Have you ever been diagnosed with any kind of breast disease: ***Y/N***

If yes, explain: _____

Obstetrical History

How many pregnancies have you had? _____ *How many children do you have?* _____

Have you had a hysterectomy? ***Y/N*** *Do you have your ovaries?* ***Y/N***

Have you had trouble maintaining a pregnancy? ***Y/N***

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?

Least				*Greatest*
o----------*o*----------*o*----------*o*----------*o*				
1	*2*	*3*	*4*	*5*

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.) _____*

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	*____Skin Rashes*	*____Back Pain*
____Constipation	*____Anxiety*	*____Memory Problems*
____Muscle Pain	*____Gas*	*____Leg Swelling*
____Shortness of Breath	*____Acne*	*____Joint Pain*
____Diarrhea	*____Headaches*	*____Insomnia*
____Urinating	*____Heartburn*	*____Hot Flashes*
____Aggression	*____Bleeding Problems*	*____Feeling "cold"*
____Indigestion	*____Fatigue*	*____Menstrual Cramps*

Other:

_____

_____

If you do not want a hormone consult, skip this page

SYMPTOM LIST……IMPROVE YOUR AWARENESS…… FOR WOMEN

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)

ESTROGEN	*Start*	*30 days*
Hot Flashes	____	____
Night Sweats	____	____
Vaginal Dryness (painful intercourse)	____	____
Water Retention	____	____
Memory Lapse	____	____
Sleep Problems	____	____
Headaches	____	____
Incontinence	____	____
Thinking problems	____	____
Menstrual Bleeding	____	____
Depression	____	____
Continuous Fatigue	____	____
Weight Gain	____	____
Wrinkles around mouth, eyes, cheek	s____	____
Irritable	____	____
Loss of scalp hair	____	____
Bone Loss	____	____
Heart palpitations	____	____
PROGESTERONE		
Tender breasts	____	____
Nervousness/Anxiety	____	____
Fibrocystic breasts	____	____
Thick uterine lining (excessive bleeding)	____	____
Uterine fibroids	____	____
Mood swings/irritability	____	____
Premenstrual tension (PMS)	____	____
DHEA		
Dry eyes	____	____
Poor pubic hair	____	____
Noise sensitivity	____	____
Excess body odor	____	____
CORTISOL		
Sugar cravings	____	____
Fibromyalgia	____	____
Increased aches & pains	____	____
Increased allergies	____	____
Inability to handles stress	____	____
Salt cravings	____	____

THYROID	*Start*	*30 days*
Morning Fatigue	____	____
Hypertension	____	____
Nocturnal Cramps	____	____
Morning hoarseness	____	____
Dry Skin	____	____
Diffuse Hair Loss	____	____
Morning Stiffness	____	____
Low Back Pain	____	____
Carpel tunnel syndrome	____	____
Sensitive to cold	____	____
Poor Circulation	____	____
Constipation	____	____
Puffy Face	____	____
Partial eyebrows	____	____
Thin brittle striated nails	____	____
Edema hands, face, eyelids	____	____
Low body temperature	____	____
TESTOSTERONE		
Increase facial/body hair	____	____
Acne, greasy hair	____	____
Lack of self assurance	____	____
Decrease muscle strength	____	____
Tired all the time	____	____
Aggressive behavior	____	____
Decrease libido/sex drive	____	____
GROWTH HORMONE		
Evening fatigue	____	____
Fatty cushions above knee	____	____
Dropping triceps	____	____
Sagging facial cheeks	____	____
Thin lips/skin	____	____
Decrease muscle strength	____	____
Light sleep	____	____
Low self-esteem	____	____
Poor wound healing	____	____
MELATONIN		
Early graying	____	____
Light anxious sleep	____	____