MELISSA PARRA, CNP, LLC

www.MelissaParraCNP.com
3901 Georgia Street NE, Suite F
Albuquerque, NM 87110
P: 505-433-4349
F:505-508-1398
admin@melissaparracnp.com

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)*

15 minutes $62.50	***60 minutes (new patients) $325***
30 minutes $125	***$100 new patient deposit***
60 minutes $250	***$25 body scans***

**Body Scan is free with your initial consultation. 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 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.***

INCLUSIVE POLICY

Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, gender identity or gender expression.

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. ***My practice requires that all patients be seen yearly in person to continue care.***

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.

Patient may be discharged for more than 3 cancellations or non-compliance with scheduled follow-up visits.

NEW PATIENT DEPOSIT

A $100 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 $100. 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 $30 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.
Please remember to treat our staff with respect.

*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/MEDICAL RECORDS

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 is 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.

HIPAA regulations require 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.***

Your credit card information will be kept on file for any future changes on a secure electronic medical record if you consent.

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, have you tried?

____
____
____
____
____
____
____
____
____

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Patient Information Sheet

Last Name: ________________________________ First Name: _______________________ MI: _____

DOB: _________ Age: ______ Date: ____________

Gender: (Circle One) Male | Female | Transgender Male/Trans Man/Female-to-Male | Transgender Female/Trans Woman/Male-to-Female | Genderqueer, neither exclusively Male nor Female | Additional gender category or other please specify____________________________________ | Patient declines to specify

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?

____

Sexual Orientation

- *Straight or heterosexual*
- *Lesbian, gay or homosexual*
- *Bisexual*
- *Don't know*
- *Patient declines to specify*
- *Something else, please describe*

If answered something else:

____

____

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

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 held financially responsible for payment for services rendered by Melissa Parra CNP or her staff.

______________________________________ ______________
Patient Signature *Date*

______________________________________ ______________
Patient's Legal Representative (If applicable) *Date*

______________________________________ ______________
Melissa Parra, CNP *Date*

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 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 an 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:__________*

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
Prostatitis
High Cholesterol
Gallbladder disease/gallstones
Prostate Cancer
Diabetes
Hemorrhoids
BPH
Kidney disease
Hepatitis
Colon Cancer
Lung disease, asthma, TB
Osteoporosis/Osteopenia
Breast Cancer
Migraine headache
Thyroid disorder
Other Cancer
Fibromyalgia
Arthritis
Erectile Dysfunction (ED)
Allergies
Rheumatic fever
Birth defects
Thyroid disease
Emphysema
Epilepsy
Sexually transmitted disease
Glaucoma
Other___________________

Family Medical History-List Chronic Illness or Diseases Below

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?

Least *Greatest*

/-------------------- /----------------- /------------------ /------------------ /

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 "caregiver": ***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/ emotional disabilities of history of abuse: ***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***

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*	____*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)

TESTOSTERONE	*Start*
↓Spontaneous early morning erections	____
↓Libido or desire for sex	____
Reduced fullness of erections	____
↓Volume of ejaculate	____
Difficulty in maintaining full erection	____
Difficulty in starting/no erection	____
Mental fatigue, feeling burned out	____
Sleepiness in afternoon or early evening	____
↓ in mental sharpness	____
Change in creativity	____
↓ in initiative or desire to get involved	____
↓ in competitiveness	____
Memory changes – forgetful	____
Feeling depressed	____
Joint aches & pains	____
↓ in flexibility or increased stiffness	____
Decrease in muscle size, tone, strength	____
Decrease in stamina	____
Back pain, neck pain	____
Pull muscles or get leg cramps	____
Development of osteoporosis or arthritis	____
↑ in total cholesterol or triglycerides	____
Decrease in HDL cholesterol	____
Rise in blood sugar level or diabetes onset	____
Hypertension	____
Weight gain "beer belly"	____
↑ fat distribution in breast area/hips	____
Diagnosis of heart disease/blockage In arteries	____
Shortness of breath with activities	____
Lightheadedness, dizzy spells, ringing in ears	____
Onset of new headaches	____
Changes in visual acuity/focus (fine print)	____
DHEA	
Dry eyes	____
Noise sensitivity	____
Excess body odor	____
Light sensitivity	____

CORTISOL	*Start*
Sugar cravings	____
Fibromyalgia	____
Aches and pains	____
Allergies	____
Inability to handle stress	____
Low blood pressure	____
Salt craving	____
THYROID	
Morning fatigue	____
Hypertension	____
Nocturnal Cramps	____
Morning hoarseness	____
Dry skin	____
Morning stiffness	____
Low back pain	____
Carpal tunnel syndrome	____
Sensitive to cold	____
Poor circulation	____
Constipation	____
Puffy face	____
Partial eyebrows	____
Thin, brittle nails	____
Edema – hands	____
Low body temperature	____
GROWTH HORMONE	
Evening fatigue	____
Fatty cushions above knee	____
Drooping triceps	____
Sagging cheeks	____
Thin lips/skin	____
Decreased muscle strength	____
Light sleep	____
Low self-esteem	____
Poor wound healing	____
MELATONIN	
Early graying	____
Light anxious sleep	____