

# 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**  
**30 minutes \$125**  
**60 minutes \$250**

**60 minutes (new patients) \$325**  
**\$100 new patient deposit**  
**\$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 in person yearly 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 or Medicaid provider; therefore, you cannot bill Medicare or Medicaid 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 qualifies 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.*

*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 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.***

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***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 help 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:*

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Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_



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## Women - Patient History

Height \_\_\_\_\_ Weight \_\_\_\_\_ Change in weight 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 Dexa Scan: \_\_\_\_\_ 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: \_\_\_\_\_

***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	Colon Cancer	Other Cancer
Blood disorders	High Cholesterol	Fibromyalgia
Mental illness, depression	Gallbladder disease/gallstones	Arthritis
Hearing problems	Breast Cancer	Allergies
Stroke	Diabetes	Rheumatic fever
Chronic fatigue syndrome	Hemorrhoids	Birth defects
Lupus	Ovarian / Cervical cancer	Thyroid disease
Anemia	Kidney disease	Emphysema
Seizure disorder	Hepatitis	Epilepsy
Skin disorders	Polycystic ovaries (PCOS)	Sexually transmitted disease
Heart disease	Lung disease, asthma, TB	Glaucoma
Ulcers	Osteoporosis/Osteopenia	Other _____
Frequent bladder infections	Uterine Fibroids	

Family History- List Illness or Diseases Below

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	
/-----/	/-----/	/-----/	/-----/	/-----/	/-----/
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 or 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

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	___ 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:

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\*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)

<u>ESTROGEN</u>	<u>Start</u>	<u>THYROID</u>	<u>Start</u>
Hot Flashes	_____	Morning Fatigue	_____
Night Sweats	_____	Hypertension	_____
Vaginal Dryness (painful intercourse)	_____	Nocturnal Cramps	_____
Water Retention	_____	Morning hoarseness	_____
Memory Lapse	_____	Dry Skin	_____
Sleep Problems	_____	Diffuse Hair Loss	_____
Headaches	_____	Morning Stiffness	_____
Incontinence	_____	Low Back Pain	_____
Thinking problems	_____	Carpal tunnel syndrome	_____
Menstrual Bleeding	_____	Sensitive to cold	_____
Depression	_____	Poor Circulation	_____
Continuous Fatigue	_____	Constipation	_____
Weight Gain	_____	Puffy Face	_____
Wrinkles around mouth, eyes, cheek	_____	Partial eyebrows	_____
Irritable	_____	Thin brittle striated nails	_____
Loss of scalp hair	_____	Edema hands, face, eyelids	_____
Bone Loss	_____	Low body temperature	_____
Heart palpitations	_____	<u>TESTOSTERONE</u>	
<u>PROGESTERONE</u>		Increase facial/body hair	_____
Tender breasts	_____	Acne, greasy hair	_____
Nervousness/Anxiety	_____	Lack of self-assurance	_____
Fibrocystic breasts	_____	Decrease muscle strength	_____
Thick uterine lining (excessive bleeding)	_____	Tired all the time	_____
Uterine fibroids	_____	Aggressive behavior	_____
Mood swings/irritability	_____	Decrease libido/sex drive	_____
Premenstrual tension (PMS)	_____	<u>GROWTH HORMONE</u>	
<u>DHEA</u>		Evening fatigue	_____
Dry eyes	_____	Fatty cushions above knee	_____
Poor pubic hair	_____	Dropping triceps	_____
Noise sensitivity	_____	Sagging facial cheeks	_____
Excess body odor	_____	Thin lips/skin	_____
<u>CORTISOL</u>		Decrease muscle strength	_____
Sugar cravings	_____	Light sleep	_____
Fibromyalgia	_____	Low self-esteem	_____
Increased aches & pains	_____	Poor wound healing	_____
Increased allergies	_____	<u>MELATONIN</u>	
Inability to handles stress	_____	Early graying	_____
Salt cravings	_____	Light anxious sleep	_____