



Dr. Linda S. Young, DNP

Welcome to Compassionate Care

Thank you for trusting us with your healthcare needs. We are committed to providing you with the best care possible. Compassionate Care follows a team-based approach with a fantastic care team that is committed to keeping you healthy, with you being the center of the team. Dr. Linda Young DNP will share her medical expertise with you, and hope you'll take responsibility for working toward the healthy lifestyle that is so important to your well-being.

As a new patient we ask that you have copies of your medical records from any other health care providers sent to us. A medical record release form is included in this packet. If you need help, please speak to our staff. If you have any appointments in the future with other providers, please ask that they share information about your visit with us too.

To schedule appointments with Compassionate Care please call (401) 767-8766

Our Office Hours Are:

Mon, Tues & Thurs	8am - 4pm
Wednesday	8am - 5pm
Friday	8am - Noon

We aim to meet your needs in a timely fashion, including offering same day appointments if you are sick today. We encourage you to call as early as possible to book these appointments.

If you are unable to keep an appointment, please call 24 hours ahead of time so we may give that appointment time to another patient needing it.

If you have a medical emergency, call 911 or proceed directly to the emergency room. For any other medical needs, call us first.

If you have a medical issue after regular office hours that cannot wait until the next business day, you can call us to speak with a medical provider.

Please bring your insurance card, picture ID and payment with you to each appointment. If you do not have health insurance, we encourage you to visit www.healthsourceri.org for information about obtaining affordable coverage.

Visit our website to see our services or to download any additional forms:
www.drlyndayoungdnp.com

We look forward to working with you as your primary care provider. Please contact us whenever you'd like to talk about anything you think may be affecting your health. It's our hope that we can have a relationship where the lines of communication are open. Let's work together to help you live the satisfying life that you deserve.

Sincerely,

Your Compassionate Care Team.

6 Blackstone Valley Place
Building 1, SUITE 100
Lincoln, RI 02965



Tel: 401 - 767 - 8766
Fax: 401 - 425 - 5446

Dr. Linda S. Young, DNP

PATIENT REGISTRATION

Please provide your photo identification and insurance cards to the front desk.

Last Name		First Name		M.I.
Date of Birth		Social Security		Birth Sex <input type="checkbox"/> M <input type="checkbox"/> F
Current Gender <input type="checkbox"/> M <input type="checkbox"/> F	Gender Identity	Sexual Orientation		Preferred Pronoun

RACE:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other Race
- Patient Declined

LANGUAGE:

- English
- Spanish; Castilian
- Other: _____

ETHNICITY:

- Hispanic or Latino
- Not Hispanic or Latino
- Patient Declined

MARITAL STATUS:

- Married
- Single
- Widowed
- Divorced
- Separated
- Partner

Address		City		State	Zip
Home Phone		Cell Phone		Check Preferred Communication: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Mail	
Email					
Emergency Contact Name		Relationship to Patient		Emerg. Contact Phone	

Are you visually impaired? Yes No Describe: _____

Are you hearing impaired? Yes No Describe: _____

Translation service requested? Yes No List Language: _____

Do you have an Advance Directive? Yes No Would you like an Advance Directive packet? Yes No

PHARMACY SELECTION:

Phone					
Address		City		State	Zip

Patient Signature: _____

Date: _____



Dr. Linda S. Young, DNP

PATIENT REGISTRATION

Please provide your photo identification and insurance cards to the front desk.

Last Name	First Name	D.O.B.
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PRIMARY INSURANCE		
Insurance Plan	Policy ID#	Group#

SECONDARY INSURANCE		
Insurance Plan	Policy ID#	Group#

By Signing Below You Agree To The Following:

I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits or payments from insurance company for physician services to be made directly to Compassionate Care, Inc. and/or Dr. Linda S. Young, DNP for the services rendered. I permit a copy of this authorization to be used in place of the original.

I understand that I am financially responsible for any balance not covered by my insurance.

I understand the cost of administrative forms is not covered under my insurance and I the patient will be responsible for a fee of \$20.

I acknowledge and understand there is a **\$25 fee not covered by insurance for missed appointments or appointments canceled in less than 24 hours of the scheduled appointment date.**

I understand that if **my insurance deductible is unmet, the office policy is to collect \$100 towards my deductible.**

If my insurance company requires referrals, the office of Dr. Linda S. Young, DNP will **process outgoing referrals within 3 business days.**

In addition, **all co-payments fees, and balances need to be collected prior to your visit.**

Patient Signature: _____

Date: _____



Dr. Linda S. Young, DNP

NEW PATIENT HEALTH HISTORY

Last Name	First Name	D.O.B.
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Medication List, including over the counter meds

List Allergies and reactions

PLEASE CHECK ANY CONDITION YOU HAVE HAD OR PRESENTLY HAVE NOW:

	YES	NO		YES	NO		YES	NO
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>	Liver Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urinating	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Breast Masses/Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>
Change in Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Tightness	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol High	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Coughing Blood	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature: _____	Date: _____
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NEW PATIENT HEALTH HISTORY

Last Name	First Name	D.O.B.
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Do you see any other physicians?	Reason

Prior Surgeries	Date

Previous Exams and Tests	Date		Date
Last Physical Exam		Last Eye Exam	
Last Colonoscopy		Last Flu Shot	
Last OB/GYN Exam		Last Tetanus Shot	
Last Mammogram		Last Blood work and Where	

FAMILY HISTORY

Mother |Father |Brother |Sister |

Mother |Father |Brother |Sister |

Patient Adopted

Alive and well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CAD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

RECENT TRAVEL HISTORY

Out of State State: _____ Out of Country Country: _____

Patient Signature: _____ **Date:** _____

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MEDICAL RECORDS RELEASE REQUEST

PLEASE PRINT CLEARLY

Patient Name	D.O.B.
Patient SSN:	Today's Date:

I AM THE ABOVE PATIENT AND I AUTHORIZE RELEASE OF MY MEDICAL RECORDS FROM:

Provider Name	Provider Address		
Provider Phone	City	State	ZIP
Provider Fax	Name of Contact		

DISCLOSE TO: **Dr. Linda S. Young, DNP** **Lincoln, RI 02895**
6 Blackstone Valley Place, Bldg 1 Ste 100 **tel 401-767-8766 / fax: 401-425-5446**

Type of Information/documents you wish to have released:

- Face Sheet/Registration EKG Results
 History and Physical Medication List
 Progress Note(s)-Dates of Service: _____ Labs/Xrays/Diagnostic Image Reports
 Other: _____

Reason for Request: On-going care Transfer Care Other: _____

I understand that if my record contains sensitive information such as mental health information, drug and alcohol abuse information or IDV related information, separate authorizations will be required.

I understand that I have the right to revoke this authorization at any time and that if I revoke this authorization, I must do so in writing and present my written revocation to Compassionate Care, Inc. I understand that my revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance carrier as the law provides my insurer the right to contest a claim under my policy.

Unless I specify otherwise, this authorization will expire in six (6) months from the date signed below. I understand that it is not necessary for me to sign this form in order to receive health care treatment.

Patient Signature: _____ **Date:** _____



Dr. Linda S. Young, DNP

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

Patient Name: _____

Patient Address: _____

Provider Name: Dr. Linda S. Young, DNP

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices. This notice describes how medical information about me may be used and disclosed, and how I can get access to this information. In addition, I give permission for this office to discuss my medical records with other doctor's offices, specialists, hospitals, and radiology facilities. I also give permission for the following person(s) to receive medical information on my behalf (please check one):

No One Else

Print Name Relationship telephone date

Print Name Relationship telephone date

Print Name Relationship telephone date

- | | |
|-------------------------------|-------------------------------|
| <input type="checkbox"/> 2025 | <input type="checkbox"/> 2028 |
| <input type="checkbox"/> 2026 | <input type="checkbox"/> 2029 |
| <input type="checkbox"/> 2027 | <input type="checkbox"/> 2030 |

Patient Signature: _____ **Date:** _____



Dr. Linda S. Young, DNP

PATIENT CARE AND PAYMENT RESPONSIBILITY POLICY

I acknowledge the responsibility for the payment of services you render to me. I understand that the payment for those services is due at the time of services unless other financial arrangements have been made prior to treatment.

I understand that I should notify the appropriate staff at your office of a change in my insurance coverage.

I understand that I am responsible for any co-payments and visit fees incurred (exhausted benefits, deductibles, etc.) that are not reimbursed by my insurance provider. **I understand that payment of those fees is due at the time of service.**

I understand that my appointment is a time exclusively reserved for me and unless I call at least one business day before my scheduled appointment. I may be charged a \$25.00 fee for the appointment that was missed due to not canceling the appointment.

After three (3) missed appointments, the Office Manager will discuss the matter with me. The Office Manager with approval of the Doctor has the right to, and may choose to, discontinue services.

I further understand that any fees resulting from missed or no call/no show appointments are not billable to my insurance company.

I understand that if I am not complying with the mutually agreed upon treatment plan, missing appointments and/or disruptive/inappropriate towards any of the staff, the Doctor may request to discontinue treatment.

I understand that if I do not make payment for services not covered by the insurance, the Doctor reserves the right to suspend treatment upon appropriate 45-days prior written notice. If the Doctor determines the treatment is to be discontinued for any reason, I will continue to be treated for a maximum of 30 days following my notification of that decision. This office will send copies of my records to my new provider upon receipt of my written authorization to do so.

I read and fully understand the above policies for patient care and payment responsibility.

Patient Signature: _____

Date: _____



Dr. Linda S. Young, DNP

AUTHORIZATION AND CARE/RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

CONSENT TO TREAT

The term "health care provider(s)" in this document means Compassionate Care, Inc., its agent and employees, members of the medical staff, their agents and employees, and other health care practitioners who provide care to patients.

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for care including future treatment. I understand that this information serves as:

1. Basis for planning my treatment and care
2. Information used to file my claim with the insurance company (procedure and diagnosis)
3. Means by which a third-party payer can verify that billed services were actually provided
4. A tool for routine health care operations including assessing quality and reviewing competency of your staff and/or other health care providers

I understand that I have been provided with the Notice of Information Practices that provides more complete information of uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment, or health care operations and that the organization is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the organization has already taken action on my behalf. Permission is hereby granted to all health care providers involved in my care to administer such examination, treatment, testing, and procedures as are deemed necessary in the course of my care.

RELEASE OF INFORMATION

Information about me necessary to substantiate my insurance claims may be released by the health care provider involved in my care.

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

For those health care providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the health care providers are not paid after reasonable notice, that account shall be deemed delinquent and a service charge shall be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND RELEASE OF INFORMATION

I request that payment of authorized medical benefits be made either to me or on my behalf to Compassionate Care, Inc. for any services furnished me by the provider/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.

I understand my signature requests that payment be made and I authorize release of medical information necessary to pay the claim. If other health insurance is indicated on item 9 of the CMS-1500 claim form or elsewhere on the approved claim form or electronically submitted claim, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE

DATE

WITNESS

TITLE

DATE