117 Eddie Dowling Hwy, LLB
North Smithfield, RI 02896

Compassionate Care, Inc

tel: 401-767-8766
fax: 866-486-1245

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 ☐ M ☐ F
Current Gender ☐ M ☐ 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:** ☐ Home Phone ☐ Cell Phone ☐ 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:** ______________

117 Eddie Dowling Hwy, LLB
North Smithfield, RI 02896

tel: 401-767-8766
fax: 866-486-1245

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.

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 i**f 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:** ______________

117 Eddie Dowling Hwy, LLB
North Smithfield, RI 02896

tel: 401-767-8766
fax: 866-486-1245

Dr. Linda S. Young, DNP

NEW PATIENT HEALTH HISTORY

Last Name	First Name	D.O.B.

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	☐	☐	Depression	☐	☐	HIV	☐	☐
Alcohol Use	☐	☐	Diabetes	☐	☐	Hypertension	☐	☐
Anemia	☐	☐	Diarrhea	☐	☐	Insomnia	☐	☐
Anxiety	☐	☐	Difficulty Swallowing	☐	☐	Kidney Disease	☐	☐
Arthritis	☐	☐	Difficulty Urinating	☐	☐	Liver Cirrhosis	☐	☐
Asthma	☐	☐	Drug Abuse	☐	☐	Nausea/Vomiting	☐	☐
Blood Disorders	☐	☐	Epilepsy/Seizures	☐	☐	Numbness/Tingling	☐	☐
Blood in Stool	☐	☐	Frequent Urinating	☐	☐	Respiratory Problems	☐	☐
Blood in Urine	☐	☐	Gallbladder Disease	☐	☐	Skin Problems	☐	☐
Blood Transfusions	☐	☐	Gout	☐	☐	Stroke	☐	☐
Breast Masses/Discharge	☐	☐	Hay Fever	☐	☐	Swollen Ankles	☐	☐
Cancer	☐	☐	Headaches	☐	☐	TB	☐	☐
Change in Bowel Habits	☐	☐	Heart Disease	☐	☐	Thyroid Disease	☐	☐
Chest Pain/Tightness	☐	☐	Hemorrhoids	☐	☐	Tobacco Use	☐	☐
Cholesterol High	☐	☐	Hepatitis A	☐	☐	Urinary Incontinence	☐	☐
Colitis	☐	☐	Hepatitis B	☐	☐	Venereal Disease	☐	☐
Constipation	☐	☐	Hepatitis C	☐	☐	Weight Loss	☐	☐
Coughing Blood	☐	☐	High Blood Pressure	☐	☐	Weight Gain	☐	☐

Patient Signature: ______________________ **Date:** __________

117 Eddie Dowling Hwy, LLB
North Smithfield, RI 02896

tel: 401-767-8766
fax: 866-486-1245

Dr. Linda S. Young, DNP

NEW PATIENT HEALTH HISTORY

Last Name	First Name	D.O.B.

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

☐ Patient Adopted

	Mother	Father	Brother	Sister		Mother	Father	Brother	Sister
Alive and well	☐	☐	☐	☐	Diabetes	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐	Hearing deficiency	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	Hyperlipidemia	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	Hypertension	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	Irritable bowel disease	☐	☐	☐	☐
CAD	☐	☐	☐	☐	Learning disability	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Migraines	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Renal disease	☐	☐	☐	☐
Other	☐	☐	☐	☐					

RECENT TRAVEL HISTORY

☐ Out of State   State: ☐ Out of Country   Country:

Patient Signature: ______________________ **Date:** ____________

117 Eddie Dowling Hwy, LLB
North Smithfield, RI 02896

tel: 401-767-8766
fax: 866-486-1245

Dr. Linda S. Young, DNP

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**
117 Eddie Dowling HWY, LLB
North Smithfield, RI 02896
tel: 401-767-8766 fax: 866-486-1245

Type of Information/documents you wish to have released:

- ☐ Face Sheet/Registration
- ☐ History and Physical
- ☐ Progress Note(s)-Dates of Service:____________
- ☐ EKG Results
- ☐ Medication List
- ☐ 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:**____________

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
☐				
☐				
☐				

☐ 2021 ☐ 2024

☐ 2022 ☐ 2025

☐ 2023 ☐ 2026

Patient Signature: ______________________ **Date:** ____________

117 Eddie Dowling Hwy, LLB
North Smithfield, RI 02896

tel: 401-767-8766
fax: 866-486-1245

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:** ____________

117 Eddie Dowling Hwy, LLB
North Smithfield, RI 02896

tel: 401-767-8766
fax: 866-486-1245

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