Youth For Tomorrow
Joe Gibbs Founder
OUTPATIENT SERVICES

14000 Crown Court, Ste. 302 Manassas, VA 20110 Ph # 703-396-8618 Fx # 571-364-8913

9720 Capital Court, Ste. 302 Manassas, VA 20110 Ph # 703-396-8618 Fx # 571-364-8913

6611 Jefferson St, 1st Floor Haymarket, VA 20169 Ph # 571-921-4812 Fx # 703-743-1688

6800 Backlick Road, Ste. 300 Springfield, VA 22150 Ph # 703-310-7449 Fx # 571-282-4559

19415 Deerfield Ave, Ste. 101 Lansdowne, VA 20176 Ph # 703-659-1433 Fx # 703-723-7222

20 Rock Pointe Ln, Ste. 201 Warrenton, VA 20186 Ph # 703-659-9847 Fx #540-935-2418

MINOR CLIENT CONTACT INFORMATION SHEET 17 YRS & UNDER

1. **Name**:_____/_____/_____/_____
   LAST FIRST MIDDLE INITIAL SUFFIX
2. **Date of Birth:** _____ **Age:** _____
3. **Gender**: _____ **Race:** _____ **Ethnicity:** _____
4. **Address Where Patient Resides:** _____
   STREET

   _____
   CITY STATE ZIP CODE
5. **Parents/Legal Guardian Information**: **Please full out the address portion if the address is different from where patient reside**

Parent 1/Legal Guardian 1: _____ _____
FULL NAME RELATIONSHIP

_____
STREET CITY STATE ZIP CODE

_____ _____ _____
HOME PHONE # WORK PHONE # CELL PHONE #

May Youth For Tomorrow leave a message on the phone number provided ◯ Yes ◯ No
If yes, check all that apply: ☐ Home ☐ Cell ☐ Voice only ☐ Text only ☐ Voice & Text

If no, please provide an alternate phone on which we may leave a message: _____

_____ Will you like to use this email for Tele-Behavioral Health Services**?** ◯ **Yes** ◯ **No**
EMAIL ADDRESS *ONLY ONE EMAIL CAN BE USE FOR TELE-BEHAVIORAL HEALTH*

Parent 2/Legal Guardian 2: _____ _____
FULL NAME RELATIONSHIP

_____
STREET CITY STATE ZIP CODE

_____ _____ _____
HOME PHONE # WORK PHONE # CELL PHONE #

May Youth For Tomorrow leave a message on the phone number provided ◯ Yes ◯ No
If yes, check all that apply: ☐ Home ☐ Cell ☐ Voice only ☐ Text only ☐ Voice & Text

If no, please provide an alternate phone on which we may leave a message: _____

_____ Will you like to use this email for Tele-Behavioral Health Services**?** ◯ **Yes** ◯ **No**
EMAIL ADDRESS *ONLY ONE EMAIL CAN BE USE FOR TELE-BEHAVIORAL HEALTH*

8. **If the Client is a Minor**, is there any other individuals(s) that has legal custody (rights) of said client of any kind? ◯ Yes ◯ No
   - If "Yes": Is the additional individual(s) who has legal rights in regards to this minor, fully in support of the aforementioned minor receiving mental health treatment services with Youth For Tomorrow? ◯ Yes ◯ No
   - If "Yes": Please provide the following information regarding said individual:

     a. (print):_____/_____/_____/_____
     Name Relationship Contact Phone# Fax # (include area code)

     b. Explanation of the legal custodial arrangement for the minor:

Youth For Tomorrow
Outpatient Services

14000 Crown Court, Ste. 101
Woodbridge, VA 22193
Ph # 703-396-7215
Fx # 571-285-5686

9720 Capital Court, Ste. 302
Manassas, VA 20110
Ph # 703-396-8618
Fx # 571-364-8913

6611 Jefferson St, 1st Floor
Haymarket, VA 20169
Ph # 571-921-4812
Fx # 703-743-1688

6800 Backlick Road, Ste. 300
Springfield, VA 22150
Ph # 703-310-7449
Fx # 571-282-4559

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Ph # 703-659-1433
Fx # 703-723-7222

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Warrenton, VA 20186
Ph # 703-659-9847
Fx #540-935-2418

ACKNOWLEDGMENT OF RIGHT FOR PARENTS OF MINOR CHILDREN

I understand that pursuant to Virginia Code 54.1-2969(E), my minor child shall be deemed an adult for the purpose of consenting to medical or health services needed in the case of outpatient care, treatment, or rehabilitation for mental illness or emotional disturbance.

8. **If the Client is a Minor**, please list: a. School attended: _____ b. Grade _____

9. **Emergency Contact**: _____ _____
FULL NAME RELATIONSHIP

_____
ADDRESS (IF DIFFERENT) STREET CITY STATE ZIP CODE

_____ _____
HOME PHONE # CELL PHONE #

10. Military Status of Parent/ Legal Guardian:

☐ No Military Status ☐ Active Duty ☐ Armed Forced Reserved

☐ National Guard ☐ Armed Forces or National Guard Retired ☐ Armed Forces or National Guard

☐ Discharged (any type) ☐ Dependent Family Member of Armed Forces or National Guard

11. **Primary Insurance** _____/_____/_____
INSURANCE COMPANY NAME MEDICAL ID # GROUP #

12. **Secondary Insurance** _____/_____/_____
INSURANCE COMPANY NAME MEDICAL ID # GROUP #

13. **Social Security number & the person's name of who holds the health insurance for the minor:**

_____ _____ _____
FULL NAME RELATIONSHIP SSN

14. **Is there anyone else who has this child as a beneficiary on their insurance plan?** ○ **Yes** ○ **No**

If yes, provide us with name and contact phone number: _____
FULL NAME PHONE NUMBER

15. **I have been given a copy of the YFT Orientation Packet, including Notification of my Rights and Privacy Notice.**
(Sign and date below.)

_____ _____
PRINT NAME OF PARENT/LEGAL GUARDIAN PRINT PATIENT'S NAME

_____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN SIGNATURE OF PATIENT
IF CHILD IS 13 YRS AND OLDER

_____
DATE