**MEDICAL CARE RELEASE AND PERMISSION TO TREAT FORM**

**Resident/Referral Full Name: _____________________________________________**

**Date of Birth: _______________ Social Security Number: __________________**

**The resident/referral listed above is a client of *Youth For Tomorrow New Life Center, Inc. (YFT)* located at 11835 Hazel Circle Drive in Bristow, Virginia.**

**Youth For Tomorrow New Life Center (YFT) cannot assume the responsibility for illness arising from any previous or congenital, physical abnormalities not disclosed at the time of interview or during the resident/referral's physical examination.**

*I hereby certify that I am the parent or legal guardian of the above-named resident/referral and I give Youth For Tomorrow my permission for the above-named resident/referral to be treated by YFT via telemedicine consultations or at a medical facility for any medical/dental emergency that may occur. This includes needed lab work and HIV testing. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV and the hepatitis B or C viruses. Those tests results will be shared with the healthcare worker who was exposed. In addition, I authorize YFT to have the required immunizations administered for the above-names resident/referral including the flu vaccine. I also understand that YFT will make every reasonable effort to contact me for any emergency using the contact information I have provided. YFT staff will transport and supervise all appointments. YFT nor its staff take any fiscal responsibility for said services and should not be billed for any services. I am financially responsible for all charges for said services. All charges should be billed to my insurance provider or to me if no provider information is given or is inaccurate.*

**I certify that the above-named resident/referral (initial one):**

☐ **Has Virginia Medicaid or Private Insurance (insurance card must be attached to this document) and will be billed to said organization. I agree that any copays, deductibles, over-the-counter medications, or non-covered medical charges should be billed directly to the responsible party listed below.**

Primary insurance company: _____________________ Policy number: ______________________

Secondary insurance company: ____________________ Policy number: ______________________

☐ **Has Out-of-State Medicaid (non-Virginia based copy of the insurance card must be attached to this document). I understand that many Virginia medical/dental providers will not accept out-of-state Medicaid. I agree to complete the appropriate documents necessary to obtain Virginia Medicaid for the above referenced client/referral within 72 hours of written notice, with email being acknowledged as an acceptable form of notice. These documents will be completed and provided to Youth For Tomorrow prior to or during the intake process. I also agree that any copays, deductibles, over-the-counter medications, or non-covered medical charges should be billed directly to responsible party listed below.**

☐ **Does not have insurance and <u>all</u> medical/dental expenses should be billed to the responsible party listed below**

## Responsible party

Name: ___________________________________ Relationship to resident/referral: ____________________

**This directive and consent shall be in force for the period of time that the client/referral is residing at YFT.**

Signature: ______________________________________ Date: ___________________

Street Address: ___________________________________________

City: ________________________ State: _____________________ Zip: ___________

Phone: ________________________________ Email: ________________________________

WITNESS:

Signature: ________________________________________ Date: ______________________________

Name: ____________________________________________