Client Agreement: 1816

CLINICAL CONSENT FORM

WISEWOMAN

NAME:	**DOB**	
ADDRESS		
CITY	**STATE**	**ZIP**
HOME PHONE	**CELL**	
EMERGENCY CONTACT	**RELATIONSHIP**	
HOME/CELL PHONE		

The Florida Department of Health invite you to take part in the WISEWOMAN programs. If you agree, you will receive your breast and cervical cancer examinations, assessments for heart disease and stroke, referral to approved healthy behavior support options and routine follow-up from a WISEWOMAN community health worker.

CLIENT AGREEMENT

- I have not supplied documentation of household income. I declare my household income is within FBCCEDP/WISEWOMAN present income guidelines. _____ **(If applicable, please initial**)
- A staff person has informed me of which tests the WISEWOMAN programs cover and possible side effects of the tests.
- I understand that the WISEWOMAN services will be available to me at no cost.
- I understand that my health is my responsibility. I am responsible for keeping my appointments.
- I understand that persons associated with WISEWOMAN may contact me in receiving medically recommended services.
- I understand that I need to contact this clinic for my test results.
- I understand that no test is 100% accurate.
- I agree to participate in both the screening tests and the WISEWOMAN lifestyle education sessions.

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- I understand that I will be contacted to return in one (1) year to see if my health status related to these services has changed.
- I have read or had the above read to me. I agree that all the information above is correct.

With your consent, as a client receiving services funded by WISEWOMAN, your protected health care information will be shared with appropriate staff at the Florida Department of Health and other agencies as required by the federal funding source. I acknowledge that I have been given a copy of the Florida Department of Health Notice of Privacy Policies and have been told where I can obtain any subsequent revisions to this Notice. If this document is signed by the guardian or Durable Power of Attorney for Health Care (DPOA-HC), attach a copy of the Letters Appointing the Guardian or a copy of the Durable Power of Attorney for Health Care.

_____ _____/_____/_____

Signature of Client/Guardian Date

_____ _____/_____/_____

Witness Signature Date