

Tri-County Health Department
Peak Wellness Program Consent Form

I, _____, do hereby give my consent to the clinical staff of Tri-County Health Department to examine, treat, and counsel me. The health information I give will be kept private.

For breast and/or cervical cancer screening, I understand and agree with the following:

1. I understand there are certain hazards and risks associated with all forms of medical treatment and care and this exam may not tell me if I have a health problem.
2. I agree to the following services that are free to me and paid for by Women's Wellness Connection:
 - I agree to have a clinical breast exam to detect breast abnormalities.
 - I agree to have a pelvic exam and Pap test, if indicated, to detect pelvic abnormalities and cervical cancer.
 - I agree to have a mammogram to detect breast abnormalities.
 - I understand medical follow-up for a breast or cervical problem is usually provided at no charge to me.
 - **I accept the responsibility for medical follow-up, if recommended.**
3. I understand if other services are provided at Tri-County Health Department outside those listed in #2, there may be a fee at the time of service. Birth control is provided on a sliding scale.
4. I understand I can come back to Tri-County Health Department in one year for another physical exam/screening for breast and/or cervical cancer, if I still qualify for the Peak Wellness program.

For health screening for heart disease risks, I understand and agree with the following:

1. I understand these screenings do not take the place of a medical exam and may not tell me if I have a health problem.
2. I understand and agree to the following parts of the health screenings and counseling offered:
 - I agree to accurately answer questions about my medical history and health habits.
 - I agree to have my blood pressure checked.
 - I agree to get a finger-stick that will check my blood for cholesterol & blood sugar.
 - I agree to have my height and weight checked.
 - I agree to talk to a registered nurse and registered dietitian about how to make small steps toward better health that will reduce my risks for heart disease, stroke, and diabetes and live a healthier life.
 - I agree to consider participating in additional free opportunities throughout the year.
 - I understand that there are certain things to consider when talking to the dietitian about physical activity:

I have been told by a doctor or nurse to limit physical activity to less than a brisk walk.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I feel chest discomfort or pain when I am physically active or resting.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have bone, back, or joint pain that could be made worse by a change in my physical activity.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
There is a reason why I should not do physical activity without a doctor's permission.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. I understand if any of the health screenings are not normal, I may be referred to another health clinic for follow-up diagnostic testing and treatment.
 - I understand I will receive a medical referral for follow-up for a high blood pressure, high cholesterol, &/or high blood sugar.
 - I understand that one visit to a referral provider for high blood pressure, high cholesterol, &/or high blood sugar may be free. For other services, I am responsible for participating in financial screening and will be responsible for charges with that agency.
 - **I accept the responsibility for medical follow-up, if recommended.**
4. I understand I can come back to Tri-County Health Department in one year for another health screening for heart disease risks, if I still qualify for the Peak Wellness program.

I have read the above information. It has been explained to me, and I believe that I understand it. Any questions that I had have been answered by a person from Tri-County Health Department.

Signature of Client

Date

The client received the above information and I believe it was understood.

Signature of Staff

Date

Patient Label