



ENCY#		CHART#		eCaST ID	
	PA	TIENT INSTRUCTIONS: Plea	ase read this page carefully before s	gning below.	
ST NAME*		FIRST NAME*	MIDDLE NAME*	MAIDEN NAME*	
T 4 NUMBERS OF YOUR SOCIAL SECURITY NUMBER*		DATE OF BIRTH*	AGE*		
	I understand th	nat by enrolling in Women 's W	ellness Connection(WWC)I agree to v	what is written on this form:	
	I understand that the Wome ment.	n 's Wellness Connection (	WWC) is a program run by the Colo	orado Department of Public Health and Enviro	
	WWC is a breast and cervical cancer screening program. WWC does not cover the costs of care that are not associated with breast or cervical cancer screenings.				
	WWC does not pay for some tests. WWC does not pay for ANY cancer treatment. I have talked to someone from this clinic about what choices have and understand that I may have to pay for some tests and treatment that WWC does not cover.				
	I do not have Medicaid, Medicare, or other health insurance that will pay for these tests or my health insurance has a high deductible or cope that I cannot afford. I understand that if I do have health insurance and it covers cancer treatment, I will not be eligible for the Breast and Cervi Cancer Medicaid Program if I am diagnosed with breast or cervical cancer through the program.				
	WWC has rules about who may enroll in the program. All of the information I have given to the clinic is true as far as I know. If I tell the clinic somether that is not true, I may not get these tests, I may have to pay for any tests done, and I may not be eligible for the Breast and Cervical Cancer May caid Program if I am diagnosed with breast or cervical cancer through the program.				
	I understand that WWC will receive some of my breast and cervical health related information. This may include parts of my medical history, test result and insurance information. WWC is very careful to keep my information private.				
	I understand that WWC looks at the breast and cervical health information of the women enrolled in the program to help improve the health of a women. They also look at demographic information.				
	My doctor, clinic, hospital, laboratory, and mammography center may share my information with: ( contract agency name ) and WWC.				
	I understand that I have the right to withdraw from the WWC program. If I no longer want to be in WWC, I will inform my healthcare provider in writing and I will be withdrawn from the program by WWC and my healthcare provider. I understand that any information shared prior to my withdrawal shall be kept by WWC.				
	I understand that I may get I	etters in the mail from my doc	tor to remind me when it is time for me	to go back to my clinic for tests or treatment.	
s	IGNATURE		DATE		