



# Cancer Screening Program

## South Puget Intertribal Planning Agency

3104 S.E. Old Olympic Highway, Shelton, WA 98584 Tel: (360) 426-3990 Fax: (360) 427-1625

### Native Women's Wellness Program (NWWP)

#### **INFORMED CONSENT/RELEASE OF INFORMATION**

Please sign to acknowledge you understand the program guidelines for SPIPA's Cancer Screening Program:

I want to be a part of SPIPA's Cancer Screening Program (NWWP)

**To be eligible, I know I must be over the age of 18, can't be over the income guidelines and be either uninsured or underinsured.**

- If I eligible, SPIPA pays **ONLY** for:
  - **Annual screening** visits which may include a for women only, a clinical breast exam by a doctor, PA or nurse, a mammogram, a pelvic exam, a pap test, an HPV test and pap/HPV lab work, and the teaching of breast self-exam.
  - Women only: Screening mammogram if I am 40 years of age or above. (or deemed high risk)
  - Approved diagnostic and follow-up services.
- SPIPA does not pay for:
  - **Screening mammogram** if I am under 40 years of age, unless symptomatic or high risk.
  - Other tests the doctor may order at my annual visit such as a urine test or blood test.
  - **Cancer Treatment.**
- I know that, if I am eligible for the SPIPA Cancer Screening Program and have other insurance coverage, my insurance company will be billed first. SPIPA will cover the co-pay or deductible for all eligible services for those that qualify.
- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by the SPIPA Cancer Screening Programs.
- SPIPA may remind me when it is time for me to go to my yearly screening exams and send information to help me learn more about my health.
- My doctor, laboratory, clinic, radiology unit and/or hospital can give the results of my breast or cervical cancer screening exams, follow-up exams and/or treatment to the SPIPA Cancer Programs.
- My name, address, social security number and/or other identifying information will be used only by this program. It may be used to let me know if I need follow-up exams. Other information may be used for studies done by SPIPA to learn more about cancer control. These studies won't use my name or other identifying information. Cancer diagnostic information will be reconciled with the Washington State Cancer Registry.

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date (MM/DD/YEAR)**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Clinic Location**

