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CONSENT to LACTATION CONSULT & FINANCIAL AGREEMENT

Client Information and Consent Form - Please print clearly or type, thank you.

MOTHER'S NAME _____

MOTHER'S DATE OF BIRTH ____ / ____ / ____

MOTHER'S OCCUPATION _____

MOTHER'S PHYSICIAN _____

MOTHER'S PHYSICIAN'S Phone # (____) ____-____

FATHER'S NAME _____

FATHER'S OCCUPATION _____

INFANT'S NAME _____

INFANT'S Place OF BIRTH _____

INFANT'S BIRTH WT. _____ **LBS** _____ **OZ**

INFANT'S DATE OF BIRTH ____ / ____ / ____

INFANT'S PHYSICIAN _____

INFANT'S PHYSICIAN'S Phone # (____) ____-____

INFANT'S PHYSICIAN'S Fax # (____) ____-____

MOTHER'S PHONE (____) ____-____

FAMILY'S ADDRESS _____

CITY, STATE, ZIP _____

Who referred you to this practice? _____

CONSENT AGREEMENT to be READ, CHECK to AGREE & SIGNED before the Lactation Visit

I understand the following: The lactation consultant is an allied health care provider and responsible for evaluating and recommending a care path to resolve or improve breastfeeding issues. A lactation visit includes a detailed history of mother/infant, an assessment of maternal/infant anatomy, observation of a feeding for evaluation of technique and effectiveness of feeding, and recommendations for management to improve and/or resolve breastfeeding related issues. All clients are provided with a written and/or oral care path to improve breastfeeding concerns. The client and the lactation consultant each have responsibilities in this path. Resolution of a breastfeeding problem often takes several days or weeks and may require a change in the original recommended care path at some point.

I understand that I am responsible for informing the lactation consultant of changes I feel are necessary in the care path at the time of the visit or during the course of follow-up communications. Phone contact during the time following the lactation visit is crucial and considered an extension of this visit. I understand I will be given a phone number to call to report progress or to communicate continued problems or concerns. **I understand it is my responsibility to call the lactation consultant with progress reports, questions or concerns.**

I understand any change from my physician's recommendations should be discussed with the physician. Health care issues of a medical nature **MUST** be discussed with a physician.

I understand a partial or follow-up visit is sometimes necessary. I understand that breastfeeding supplies and/or breast pumps may be recommended as effective management of specific situations. Only effective breastfeeding equipment will be recommended.

I authorize the lactation consultant to release any information acquired in the evaluation and/or management of myself and/or my child to our health care providers, referring physician, referring lay breastfeeding counselor, and/or our insurance company upon request. I understand the lactation consultant may contact my physician or my child's physician if the lactation consultant feels it is necessary to consult with the physician.

I have received a copy of the lactation consultant's HIPAA Privacy Practices or understand it is available on lactation consultant's website.

I understand this practice accepts only **fee for service at time of service**. It is my responsibility to pursue reimbursement for lactation services from my insurance company. This practice does no billing for insurance reimbursement and is not a provider on any insurance plan. Reimbursement is not guaranteed, but filing is suggested.

I give permission for information, photos and/or videos of my lactation visit to be used in lactation articles, case studies or other studies for professional lactation or maternal/child education.

Signature _____

Date _____

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- PLEASE ALSO FILLOUT THE BREASTFEEDING QUESTIONNAIRE -