

Mother's Name: _____

Date of Birth: _____

Father/Partner's Name: _____

Date of Birth: _____

Infant's Name: _____

Date of Birth: _____

Referred by: _____

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

- ☐ I understand that 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 and 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 plan to improve breastfeeding outcomes. The client and the lactation consultant each have responsibilities in this plan. 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 plan at the time of the visit or during the course of follow-up communications. Contact during the time following the lactation visit is crucial and considered an extension of this visit. It may take place via telephone, email, Skype, Google+, or text. I understand that communications in these forms are **not** HIPAA compliant and that my private health information is not secure when communicating via these methods. I understand I will be given a phone number to call to report progress or to communicate continued problems or concerns. I will also be provided with a HIPAA compliant online platform if I need online services for follow-up. **I understand it is my responsibility to communicate with 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 midwife, 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 the lactation consultant is not a provider for any insurance plans. I will receive an insurance "superbill" for seeking reimbursement from my own insurance provider. I understand and agree that all services provided during the consult(s) are a **fee for service provision and must be paid in full at the time of service**. It is my responsibility to pursue reimbursement for lactation services from my insurance company, and full or partial reimbursement is not guaranteed by the lactation consultant.
- ☐ 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, and that all identifying information will be removed.

Signature: _____

Date: _____ Telephone Number: _____