



## CONSENT FORM

Date: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Mother's Date of Birth: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Baby's name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Baby's Date of Birth: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Mother's Physician: \_\_\_\_\_

Baby's Physician: \_\_\_\_\_

Mother's Physician's Phone No.: \_\_\_\_\_

Baby's Physician's Phone No.: \_\_\_\_\_

### ***Consent Agreement to be READ, INITIALED & 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 your visit. You 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 equipment will be recommended.

\_\_\_\_\_ I hereby 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 this provider's Privacy Practices.

\_\_\_\_\_ 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.

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

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