CONSENT FORM

Consent Agreement to be READ, INITIALED & SIGNED before the Lactation Visit

_________ I understand the lactation consultant is an allied health care provider and is responsible for evaluating and recommending a care plan 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 verbal care plan to improve breastfeeding concerns. 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 plan 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 communication. Phone contact after the lactation visit is important and considered an extension of the visit. **I understand it is my responsibility to call the lactation consultant with progress reports, questions or concerns.**

_________ I understand any instructions or recommendations given may be discussed with one or both of our health care providers.

_________ 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 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.

__________ 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 not currently bill for insurance reimbursement and is not a provider on any insurance plan. Reimbursement is not guaranteed, but will depend on your policy. Filing a claim is suggested even if you feel it will not be a covered benefit in your policy.

OR

__________ I understand that this practice participates with some insurance companies and will file the claim for me. If the claim is denied, the payment and any co-pay will be my responsibility.

__________ 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**_________________________

Who may we thank for your referral? ____

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