



LACTATION CONSULTATION CONSENT FORM

MOTHER

Mother information fields: Your Name, Birth Date, Age, Profession, Street Address, City, State, Zip, Partner's Name, Partner's Profession, Best phone to reach you (Home/Landline, Cell), Phone (home/landline), Phone (cell), Do you text? (Yes/No), Email, How would you prefer to receive the report from this consult? (Email, Regular Mail, Faxed To), Referred by: (Friend/Family, Hospital, Doctor), Website: (Internet search, Other referral source).

BABY

Baby information fields: Baby's Full Name, Sex (M/F), Due Date, Birth Date, Weeks Gestation at Birth, Place of Birth, City/State of Birth.

INSUR- ANCE

Insurance information fields: Insurance Company, Primary Insured's Name, Employer, Date of Birth, Relationship to Mother (Self, Spouse, Other), Member Number, Group Number.

HEALTH CARE PROVIDERS

Health Care Providers table with columns for OBSTETRICIAN / MIDWIFE and PEDIATRICIAN. Fields include Name, Send report? (No/Yes), City and State, Phone, Fax or Email.

I understand that:

- All medical care is to be provided by my own physician(s) and that any change from his/her/their recommendations should be discussed with him/her/them.
• A lactation consultation by the IBCLC may include a visual and manual assessment of the mother's breasts, the baby's mouth and suck, observation of the mother and baby breastfeeding, analysis of information relating to the breastfeeding situation, demonstration of techniques for improving breastfeeding, use of breastfeeding equipment, and recommendation of a care plan to resolve breastfeeding issues, which may be adjusted during the course of treatment.
• A student intern may accompany the IBCLC and participate in the consultation for training purposes.
• I am responsible for informing the lactation consultant(s) of any relevant information or changes that affect my breastfeeding situation.
• It is my responsibility to call the lactation consultant(s) with progress reports, questions, or concerns.
• This practice will submit a claim for direct payment of insurance benefits with participating insurance companies and bill me for any remaining co-pay or fees. For those who are not insured or who are insured with companies with which we do not participate, payment for services and supplies are my sole responsibility and required at the time of service; a receipt will be provided for insurance reimbursement.

I grant consent for:

- Information about this consultation to be mailed, faxed, or emailed to my attending physician/health care providers.
• The release of any medical information necessary to process any insurance claim(s) and payment of any insurance benefits directly to this practice.
• Information from this consultation to be used for teaching purposes, with the understanding that no names or identifying features will be used.
• Treatment according to the scope of practice outlined above.

My signature below acknowledges my understanding of the conditions set forth above.

Client Signature

Date

INITIALS

I give permission for photos and/or videos of my lactation visit to be taken and used solely for educational purposes, including presentations at professional conferences and workshops without further notice or compensation. No identifying information will be present in any photograph or video.