

**Jamie Owens, RN, IBCLC - Phone: 203-417-5961**

**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 # (\_\_\_\_) \_\_\_\_-\_\_\_\_

RCTVPGR'S NAME \_\_\_\_\_

INFANT'S NAME \_\_\_\_\_

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INFANT'S DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

INFANT'S PHYSICIAN \_\_\_\_\_

INFANT'S PHYSICIAN'S Phone # (\_\_\_\_) \_\_\_\_-\_\_\_\_

INFANT'S PHYSICIAN'S Fax # (\_\_\_\_) \_\_\_\_-\_\_\_\_

MOTHER'UPHONE (\_\_\_\_) \_\_\_\_-\_\_\_\_

FAMILY'S ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

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**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** \_\_\_\_\_