Feed the Baby LLC Consent Form

CLIENT'S NAME_____**DOB**_____ **INFANT'S NAME**_____**DOB**_____
Indicate Pronouns if Desired_____

HOME/CELL PHONE_____ **PARTNER'S NAME**_____
Indicate Pronouns if Desired_____

E-MAIL ADDRESS_____ **HOME ADDRESS**_____

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/e-mail 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/e-mail address 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 and/or I have been provided access to read these privacy practices online.

_____ I understand this practice accepts only fee for service at time of service. A superbill will be provided to me to submit to my insurance company. I understand that insurance reimbursement is not guaranteed.

_____ I do____ do not____ give permission for information, photos and/or videos of my lactation visit to be used in lactation articles or studies for professional education.

_____ I do____ do not____ give permission for (non-identifying) details of my lactation visit to be shared with other lactation professionals at LACTNET, a computer listserve, in order to gain more insight into my breastfeeding concerns.

Signature_____**Date**_____