

**Client Information and Consent Form**

**[Business Name or Your Name and Initials HERE]**

Please print clearly, thank you.

MOTHER'S NAME \_\_\_\_\_  
 MOTHER'S DATE OF BIRTH \_\_\_\_\_  
 MOTHER'S SSN \_\_\_\_\_  
 MOTHER'S PHYSICIAN \_\_\_\_\_  
 MOTHER'S PHYSICIAN'S Phone # \_\_\_\_\_  
 MOTHER'S OCCUPATION \_\_\_\_\_  
 FATHER'S NAME \_\_\_\_\_  
 FATHER'S OCCUPATION \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 Who referred you to this practice? \_\_\_\_\_

INFANT'S NAME \_\_\_\_\_  
 INFANT'S DATE OF BIRTH \_\_\_\_\_  
 INFANT'S PLACE OF BIRTH \_\_\_\_\_  
 INFANT'S BIRTH WT. \_\_\_\_\_ LBS \_\_\_\_\_ OZ \_\_\_\_\_  
 INFANT'S PHYSICIAN \_\_\_\_\_  
 INFANT'S PHYSICIAN'S Phone # \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_  
 CELL PHONE \_\_\_\_\_  
 CITY, STATE, ZIP \_\_\_\_\_

**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.

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

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

**Date** \_\_\_\_\_