

Pat Lindsey, IBCLC - Lactation Services
Pat Lindsey, IBCLC, RLC - Reg. 11111111
International Board Certified Lactation Consultant - Registered Lactation Consultant
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PATIENT INFORMATION						
PATIENT'S LAST NAME		FIRST	INITIAL	PTS BIRTHDATE	PATIENT: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO SUBSCRIBER
ADDRESS			CITY	STATE	ZIP	REFERRING PHYSICIAN
PHONE ()	SUBSCRIBER				INSURANCE CARRIER	
ADDRESS - IF DIFFERENT			CITY	STATE	ZIP	INS. ID COVERAGE CODE GROUP
<input type="checkbox"/> ILLNESS <input type="checkbox"/> ACCIDENT <input type="checkbox"/> INDUSTRIAL	<input type="checkbox"/> ILLNESS <input type="checkbox"/> PREGNANCY	SUBSCRIBER'S DATE OF BIRTH		OTHER HEALTH COVERAGE? YES <input type="checkbox"/> NO <input type="checkbox"/> IDENTIFY: <input type="checkbox"/>		
ASSIGNMENT. I hereby assign my insurance benefits to be paid directly to the undersigned health care provider. I am financially responsible for non-covered services.				RELEASE: I authorize the undersigned health care provider to release any information acquired in the course of my examination or treatment.		
SIGNED: (Insured or Authorized Person)				Date:		SIGNED: (Insured or Authorized Person)
NEW		ESTAB	OFFICE/OUTPATIENT VISIT	FEE	Individual	Group
Hx Evaluation and Management					PREVENTIVE COUNSELING	
Hx Evaluation and Management					15 Minutes Counseling	
Hx Evaluation and Management					30 Minutes Counseling	
Hx Evaluation and Management					45 Minutes Counseling	
Hx Evaluation and Management					60 Minutes Counseling	
NEW		ESTAB	HOME VISIT	FEE	BREAST PUMPS and OTHER SUPPLIES	
Hx Evaluation and Management					Double Electric Breast Pump - Brand:	
Hx Evaluation and Management					Single Electric Breast Pump - Brand:	
Hx Evaluation and Management					Hand Breast Pump - Brand:	
Hx Evaluation and Management					OTHER:	
NEW		ESTAB	CONSULT-PHYSICIAN REFERRED	FEE	Tubing for breast pump, replacement	
Hx Evaluation and Management					Adapter for breast pump, replacement	
Hx Evaluation and Management					Cap for breast pump bottle, replacement	
Hx Evaluation and Management					Breast shield: replacement used with breastpump Size:	
Hx Evaluation and Management					Polycarbonate bottle for use with breast pump, replacement	
Hx Evaluation and Management					Locking ring for breast pump, replacement	
Hx Evaluation and Management					Hydro Gel Pads	
Physician		Non-Physician	TELEPHONE CONSULT	FEE	NIPPLE SHIELDS Size:	
Brief					SUPPLEMENTAL NURSING SYSTEM Starter - Regular	
Intermediate						
Lengthy Complex						
NEW		ESTAB	HBA VISIT	UNITS	FEE	
15 min. Face-to-Face UNIT						
Lactation Class		Parenting Class		Nutrition Class		
TRAVEL				# Miles @	SALES TAX ON SUPPLIES IF NO PRESCRIPTION	
LACTATION DX ICD 9 CM CODES			JAUNDICE		CHILD DIAGNOSIS	
CHILD			<input type="checkbox"/> Newborn-Physiologic <input type="checkbox"/> Newborn-Premature <input type="checkbox"/> Breastmilk Jaundice		PRIMARY DX	
BREASTFEEDING PROBLEM			ABNORMAL FUSSINESS/COLIC		SECONDARY DX	
<input type="checkbox"/> Abnormal Weight Loss <input type="checkbox"/> Dehydration Newborn <input type="checkbox"/> Failure to Gain Weight <input type="checkbox"/> Newborn Feeding Problem <28 days <input type="checkbox"/> Breast Refusal <input type="checkbox"/> Latch-on Difficulties <input type="checkbox"/> Regurgitation of food <input type="checkbox"/> Slow feeding <input type="checkbox"/> Other <input type="checkbox"/> Vomiting >28 days <input type="checkbox"/> Infant Feeding Problem >28 days <input type="checkbox"/> Breast Refusal <input type="checkbox"/> Latch-on Difficulties <input type="checkbox"/> Mismanagement of feeding <input type="checkbox"/> Other <input type="checkbox"/> Polyphagia-Overeating <input type="checkbox"/> Under weight <input type="checkbox"/> Rapid weight gain			<input type="checkbox"/> 789.7 Colic <input type="checkbox"/> Excessive Crying of Infant <input type="checkbox"/> Sleep Disturbances Infant		MOTHER	
SUCKING PROBLEMS			DERMATITIS/INFECTION		NIPPLE/AREOLA PROBLEM	
<input type="checkbox"/> Reflex Abnormal (Infant Suck)			<input type="checkbox"/> Diaper Rash <input type="checkbox"/> Due to Food <input type="checkbox"/> Eczema/Atopic Dermatitis <input type="checkbox"/> Thrush-Newborn <input type="checkbox"/> Thrush in mouth-Infant		<input type="checkbox"/> Cracked/Fissured <input type="checkbox"/> Dermatitis Contact <input type="checkbox"/> Retracted Nipple <input type="checkbox"/> Flat or Sore Nipple <input type="checkbox"/> Inversion of Nipple <input type="checkbox"/> Nipple Thrush	
			OTHER		BREAST PROBLEM	
			<input type="checkbox"/> Ankyloglossia/Tongue-Tie <input type="checkbox"/> GERefluxNonInflam V12.70 <input type="checkbox"/> GEReflux-Inflam V12.70 <input type="checkbox"/> Macroglossia V12.40 <input type="checkbox"/> Microglossia V12.40 <input type="checkbox"/> Teething Syndrome		<input type="checkbox"/> Breast Pain <input type="checkbox"/> Dermatitis Contact <input type="checkbox"/> Galactocele <input type="checkbox"/> Hypoplasia of Breast <input type="checkbox"/> Mass (es) / Lump (s)	
					MILK SUPPLY	
					<input type="checkbox"/> Agalactia-Failure of Lactation <input type="checkbox"/> Galactorrhoea <input type="checkbox"/> Unspecified Disorder of Lactation <input type="checkbox"/> Suppressed/Reduced Milk Supply	
					ENGORGEMENT, BREAST	
					<input type="checkbox"/> Associated with childbirth <input type="checkbox"/> Postpartum Moderate/Severe	
					MASTITIS	
					<input type="checkbox"/> Breast-Abscess/Postpartum <input type="checkbox"/> Nonpurulent/Infection/Postpartum <input type="checkbox"/> Nonpurulent/Infection/Childbirth	
					ADOPTION	
					MOTHER DIAGNOSIS	
					PRIMARY DX	
					SECONDARY DX	
					ALL SERVICES AND SUPPLIES ARE NONREFUNDABLE NO RETURNS OR EXCHANGES	
INSTRUCTIONS TO PATIENT FOR FILING INSURANCE CLAIMS:				REC'D BY		TODAY'S FEE
COMPLETE THE PATIENT INFORMATION SECTION AT THE TOP OF THIS FORM. SIGN AND DATE. THEN MAIL THIS FORM DIRECTLY TO YOUR INSURANCE COMPANY. PLEASE ATTACH YOUR OWN INSURANCE CARRIER'S CLAIM FORM.				<input type="checkbox"/> CHARGE <input type="checkbox"/> CASH <input type="checkbox"/> CHECK		OLD BALANCE
PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION, REGARDLESS OF INSURANCE OR OTHER THIRD PARTY INVOLVEMENT.				#		TOTAL DUE
						AMT. REC'D
						NEW BALANCE
NEXT APPOINTMENT			PROVIDER'S SIGNATURE			DATE OF SERVICE