GBMC HEALTHCARE

Warmline 443-849-3428

Client Information and Consent Form **Please print clearly, thank you.**

PARENT'S NAME_____
Other PARENT'S NAME_____
PARENT'S PHYSICIAN_____
HOME PHONE _____
CITY, STATE, ZIP_____
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_____

Consent Agreement to be READ, INITIALED & SIGNED before the Outpatient 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. Resolution of a breastfeeding problem may take several days or weeks and may require a change in the original care path.

_____ 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 following the lactation visit is crucial and considered an extension of your visit and each patient will receive 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 that if the lactation consultant recommends any change from my provider's recommendations, that I must discuss that with my primary provider. Health care issues of a medical nature MUST be discussed with a provider licensed to practice independently.

_____ I understand a partial or follow-up visit at additional cost is sometimes necessary. I understand that breastfeeding supplies and/or breast pumps may be recommended as effective management of specific situations and will be an additional charge. I understand I am responsible for contacting my insurer to determine what breast pumps may be fully covered at no cost to me.

_____ 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 that the lactation consultant may contact my provider or my child's provider if the lactation consultant feels it is necessary to consult with the provider.

_____ I have received a copy of this provider's Notice of 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. The lactation consultant 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 am willing to have pictures taken for educational purposes if appropriate. Yes_____ No_____

Signature_____

Date_____ **Time**_____

* C O N S E N T *