**Consent Agreement to be READ, INITIALED, & SIGNED before visit.**

The lactation consultant is an allied health care provider and responsible for evaluating and recommending a plan of care to resolve or improve breastfeeding issues. By reading and signing this Consent Form you authorize Cathy Jones, IBCLC (lactation consultant) to do all of the following:

\_\_\_ I give my consent for the lactation consultant to work with me and my baby during this consultation for my breastfeeding problem/concern. This consent is for in-person visits and/or telehealth, as well as phone conversations and information sent by e-mail, text, and other messaging formats and includes appropriate follow-up contacts.

\_\_\_\_ I understand the following: 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 no outcome can be guaranteed.

\_\_\_\_For the purpose of assessment and consultation I consent to:

* Visual and physical assessment of the parent’s breast and/ or nipples.
* Visual and physical assessment of the infant’s mouth and suckling motion.
* Observation of the parent and infant nursing.
* Analysis of the data relating to the breastfeeding situation.
* Demonstration of techniques for improving breastfeeding.
* The use of breastfeeding equipment, as needed.
* Touching or holding my baby to assist with positioning, latching, and other techniques related to breastfeeding.
* Demonstration and use of equipment or supplies that may be recommended.

\_\_\_\_ I understand that I am responsible for informing the lactation consultant of changes I feel are necessary in the care plan at the time of the visit or during the course of follow-up communication. I understand it is my responsibility to call the lactation consultant with progress reports, questions, or concerns. I understand any instructions or recommendations given may be discussed with one or both of our health care providers. I understand a partial or follow-up visit is sometimes necessary. Email/phone contact during the two weeks following the consultation is crucial and considered an extension of this visit.

\_\_\_ I understand that my session includes 2 contacts for follow-up support with the lactation consultant by phone or messaging. After that time, for additional questions or requests for additional lactation support, I will need to request a follow- up consultation.

\_\_\_ I understand that I may need to acquire breastfeeding supplies or equipment as recommended in the patient’s plan of care. Only effective breastfeeding equipment will be recommended.

\_\_\_\_ 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 that a breastfeeding consultation does not substitute for medical care, and that medical care can only be provided by a physician. Any advice given in the course of this consultation cannot replace medical advice received from a primary care provider. I understand that it is my responsibility to discuss any change in my care plan with my primary care provider.

\_\_\_\_I understand that it is my choice to have someone else present during the visit and that anyone who sits in on the visit will have access to my healthcare information and my confidentiality may not be guaranteed. I acknowledge that the lactation consultant is not responsible for any breach of confidentiality made by anyone I invite to be present during a visit, or anyone added by me as a third party to text or email.

\_\_\_\_ I understand that I may, at any time, decline any and all specific techniques, breastfeeding equipment, and any and all recommendations provided.

\_\_\_\_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, 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 understand that for this lactation consultation and all follow-ups, the lactation consultant will protect the privacy of my personal health information as required by the Code of Ethics of the International Board of Lactation Consultant Examiners, and the Standards of Practice of the International Lactation Consultant Association.

\_\_\_\_I give my consent for the lactation consultant to use clinical information obtained during our sessions for education of other health care providers and mothers about lactation. I won’t be identified in any way, but aspects of my situation may be described and discussed.

\_\_\_\_ I acknowledge that the lactation consultant has provided their HIPAA policy and a HIPAA-compliant means of communication. If I choose not to use the HIPAA-compliant form of communication that the lactation consultant has provided, I understand that although email and text are not inherently secure means of communication the lactation consultant will take all reasonable precaution.

\_\_\_\_I have received a copy of this provider’s Privacy Practices.

\_\_\_I have read and reviewed Cathy Jones Lactation Service’s payment policies and acknowledge that I am responsible for all charges associated with this visit. I give my permission for information to be released to my insurance company to assist in the evaluation of a claim. I give my permission for the lactation consultant to bill my insurance and collect payment if I have not paid cash at the time of service. If I have not met my deductible, or my insurance does not pay, I agree to pay Cathy Jones, IBCLC, the lactation consultant the balance of the consult. I have been given the cash rates for consultations. I agree with the use of digital signatures in my interactions with the lactation consultant. Any signature of mine that is provided digitally will be assumed to carry all the weight and authority of an original manual signature.

Lactating Parents Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lactating Parents Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_