Client Information & Consent Form

Please print clearly, thank you.

MOTHER'S INFORMATION

MOTHER'S NAME_____DATE OF BIRTH_____
HOME ADDRESS_____
MAILING ADDRESS (IF DIFFERENT)_____
EMAIL_____
PRIMARY PHONE #_____HOME OR MOBILE (CIRCLE)
ALTERNATE PHONE # (OPTIONAL)_____
MOTHER'S OCCUPATION _____
MOTHER'S PRIMARY HEALTH CARE PROVIDER(S) - (MD/ND/MIDWIFE,ETC):
_____
MOTHER'S PROVIDER'S PH#_____ FAX#_____
PARTNER'S NAME_____
PARTNER'S DATE OF BIRTH_____
PARTNER'S OCCUPATION_____
EMERGENCY CONTACT NAME_____
EMERGENCY CONTACT PH#_____
WHO REFERRED YOU TO THIS PRACTICE? _____

BABY'S INFORMATION

BABY'S NAME_____ BABY'S DATE OF BIRTH_____
BABY'S SEX: M or F BIRTH WEIGHT_____ BIRTH PLACE:_____
BABY'S HEALTH CARE PROVIDER(S):_____
BABY'S PROVIDER'S PH#_____FAX#_____
IF MULTIPLES, ADD ADDITIONAL BABIES HERE:
NAME: _____ SEX: M or F BIRTH WEIGHT_____
NAME: _____ SEX: M or F BIRTH WEIGHT_____
NAME: _____ SEX: M or F BIRTH WEIGHT_____

INSURANCE INFORMATION

MOTHER'S POLICY: BRAND_____MEMBER #_____GROUP #_____
BABY'S POLICY: BRAND_____MEMBER #_____GROUP #_____

Dena Freedman-Muchnick, M.S., CCC-SLP, CLC
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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. Remaining in contact during the time following the lactation visit is crucial and considered an extension of your visit. You will have access to me via our private HIPPA compliant Parent Portal (Milk Notes) to report progress and/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 **fee for service at time of the 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. However, we do provide an itemized superbill and detailed instructions to submit for reimbursement. I understand that reimbursement is not guaranteed, but filing is suggested.

_____I give permission for information, photos and/or videos of my lactation visit to be used on social media or website for promotional purposes, and in lactation articles or studies for professional education.

Signature_____**Date**_____

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