Postpartum Doula Contract

The following is a summary of the postpartum support services I (the Doula) agree to provide in exchange for my service fee.

Postpartum Education & Support Details:

I agree to provide non-medical physical, emotional and informational support after the birth of your baby.

This can include help with self-care, recovery, postpartum comfort measures, infant care, parenting information, and providing assistance with learning to feed and take care of your baby.

Practical support can include but is not limited to:

- Support with all infant feeding (breast, chest, bottle
- Newborn care – the parents/family's choices and learning process.
- Meals - Cooking, snacks, grocery shopping, family-friendly food
- Errands
- Assistance with other family and/or pets in the house
- Laundry -Unbelievable amounts of laundry
- Care for the newborn while you take time for personal care and/or other tasks you need both hands for.
- Peace of mind for partners, family and friends after they return to work.
- Evidence-based information to support you in making the best decisions for your family
- Light housework

Physical Support Responsibilities:

The tasks I perform each day/night will depend on the priorities discussed by all parties before beginning services, and on your particular needs that day/night.

Part of my responsibility as a trained professional is to ensure the safety and well-being of all members of the family I have been hired by. In the event that I am witness to any instances of abuse or neglect, I have an obligation to report it to the relevant and appropriate authorities and family services.

I agree to be clear and forthcoming about any concerns (should I encounter any).

In the event that I feel unsafe or threatened in the home, I reserve the right to leave immediately and terminate further services without penalty and with no obligation to provide any kind of refund or replacement of services.

It is important to note that as a Doula it is not within my scope to provide childcare while a parent is not in the home, to do any heavy cleaning or organizing, or to give any medical advice with regards to your postpartum healing.

Doula/Client Expectations

What you can expect from me:

- I will keep you and your partner informed and educated during support shifts and via call/text support through each milestone of your pregnancy and postpartum journey.
- I will help you find evidence-based information about different options postpartum.
- I will be an unbiased resource.
- I will provide you, and your partner if you have one, reassurance and encouragement
- I will provide a caring and empathetic attitude
- I will help you and your partner work through fears and self-doubt about parenting and recovery.
- I will help you, and your partner if you have one, debrief after birth.
- I will provide physical support to you in your home during the postpartum period.

What I expect from you:

- I hope that you will have an open and receptive attitude towards postpartum education.
- It is your responsibility to obtain medical prenatal care from a trusted healthcare provider.
- I understand that the postpartum period is emotionally charged! I ask that respectful language and communication be used at all times.
- I hope that you will be direct with me should you have any complaints.
- Please ensure that payments are made on the agreed-upon dates and that you communicate clearly if you are in need of accommodation.
- Please respect my personal time by keeping calls to reasonable hours outside of the on-call period.
- I hope that you will feel comfortable enough to be open and honest about your needs along the way.

Confidentiality Statement:

All of your personal information will be kept private and will never be shared with anyone. and will be used solely to help me best support you.

I agree to dispose of your personal information after the conclusion of our contract unless given your express permission to keep it on file for future services should you want them.

It is your right to omit any sensitive information from the intake questionnaire that you are uncomfortable disclosing.

It is your responsibility to share any and all relevant medical information with your healthcare provider.

Financial Agreement & Refund Policies

Fees and Payments:

A deposit of $_____(= _____weeks of anticipated hours) will be due upon signing of this contract. This deposit will be applied to the last _____weeks of care. Payments are due every _____weeks. In the event that you choose not to use my services, the deposit will not be refunded. Services are expected to begin around (date) _____. I require at least _____hours notice prior to beginning services. Preferably, I will be notified upon the birth of the baby.

Payment Options:

☐ Hourly - $_____Hr ☐ ____Weeks of care - $_____

☐ _____ Months of care - $_____

Please select your preferred method of payment:

☐ E-Transfer ☐ PayPal ☐ Cash ☐ Check ☐ Other (please specify): _____

Overnight Services:

Overnight services are included in this contract: ☐

The minimum number of hours for overnight shifts (should you require them) is_____. The cost of service is $_____/hr for overnight services. I am available for prenatal consultation to address concerns and learn the needs of the expectant family. The charge for a consultation is $_____.

Payment Arrangement Details:

_____

_____

_____

Prior to signing this agreement, I will disclose any potential scheduling difficulties I anticipate which may interfere with services and work with you to ensure you still receive the care you require.

In the event of illness, emergencies or other unexpected and or extraordinary circumstances, for either party, every effort will be made to reschedule services at another time.

If any payment for that day has already been made, it will be applied to future services.

Scheduling & Special Circumstances

Please fill out your desired weekly support hours below:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
____ AM/PM To ____ AM/PM	____ AM/PM To ____ AM/PM	____ AM/PM To ____ AM/PM	____ AM/PM To ____ AM/PM	____ AM/PM To ____ AM/PM	____ AM/PM To ____ AM/PM	____ AM/PM To ____ AM/PM

____ Hours of support over the course of ____ Weeks.

- I will not provide services in any client's home while experiencing COVID-19 symptoms and/or after a positive COVID-19 test. I reserve the right to postpone services until I receive a negative COVID-19 test and/or have been symptom-free for _____ days.

- I will not provide services in any client home that is experiencing COVID-19 symptoms. A negative test is required to resume services.

- In the event that I am unable to attend shifts due to COVID-19 symptoms those missed hours can be rescheduled.

- In the event that you cancel a shift due to you or a member of your household is showing COVID-19 symptoms those hours can be rescheduled.

- No refunds will be given for hours missed due to COVID-19 should you decline to reschedule them. I reserve the right to offer any kind of refund at my discretion depending on mitigating circumstances.

This contract is drawn up and agreed to by the following persons as designated by their signatures below:

_____ Date:_____
_____ - Postpartum Doula

_____
_____
(please print names here)

_____
_____
Signatures of Birther (and partner if they have one) Date: _____

New Client Intake Questionnaire

Personal & Contact Info:

Name(s): _____

Pronouns: _____ Clients Birth Date: _____ Due date: _____

Address: _____

Email Address: _____ Phone Number: _____

Partners Phone Number: _____ Calls, texts or emails preferred? _____

Emergency Contact Name_____ Relationship: _____

Phone Number: _____ Alt. Phone Number: _____

About Your Family:

Baby(ies) Name(s): _____ Baby(ies) Birth date: _____

Intended Place of Birth:_____ Dr./Midwife Name: _____

Dr/Midwife Phone #: _____ Are you taking time off work? ☐ YES ☐ NO

☐ UNDECIDED If so, how long? _____ Is your partner taking time off work? ☐ YES

☐ NO ☐ UNDECIDED If so, how long?_____ Any known allergies int he family? ☐ YES

☐ NO If Yes, Please Specify: _____

Do you have any Pets? ☐ YES ☐ NO If Yes, Please Specify: _____

Do you, or your partner if you have one smoke in the home? ☐ YES ☐ NO

How do you plan to feed your baby? ☐ Breastfeeding ☐ Formula ☐ Combination Feeding

☐ Exclusive Pumping/Bottle feeding ☐ OTHER (Please Specify):_____

Do you have any other children? ☐ YES ☐ NO If yes, please list their names and ages:

_____

_____

Important Medical Information

Do you have any other medical conditions I should be aware of, including allergies to essential oils or honey? YES NO

If yes, please specify:

_____

_____

Do you currently see any of the following practitioners: YES NO

Chiropractor Pelvic Floor Therapist Physiotherapist Acupuncturist Aroma Therapist

Dietician/Nutritionist Naturopath Psychologist Psychiatrist Other (please specify):

_____

If yes, for what reasons?:

_____

_____

Do you or your partner have a history of mental health concerns or illness? YES NO

If yes, please specify (optional): _____

Are you currently taking any medications? YES NO

If Yes, please specify (optional): _____

Do you anticipate your baby to have any medical concerns? YES NO

If yes, please specify: _____

Insurance & Benefits

Do you plan on claiming birth doula support on your benefits/insurance plan? YES NO

Will you be needing a receipt in order to be reimbursed for birth doula support by your insurance/benefits company? YES NO

Is there anything else you need in order to claim postpartum doula support in any way? (please specify):

_____

_____

_____

Tell me about yourself!

Are there any parenting techniques you plan to use or have questions about?

What are your primary goals in having a Postpartum Doula?

How did you hear about my services?

Do you have any fears about parenting or the postpartum period?

What time of day do you anticipate Postpartum Doula services will be the most needed?

What tasks do you anticipate you will like the most help during the postpartum period?

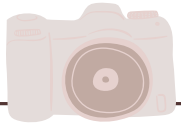
Anything you would like to add?

Thank you for taking the time to fill out these forms!

Postpartum Photo, Video & Media Release

I/we, the client(s), agree to the following (check all that apply):

____ I would like photographs to be taken.
____ I would like video to be taken.



Requested Captures

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

I would like photos/video taken:

____ ongoing during the first days/weeks
____ only during the first day or two with our newborn

I would like to use:

____ my camera
____ their camera

Preferences surrounding graphic/intimate photos:

____ No intimate photos, please (ie of breastfeeding)
____ I don't mind intimate photos being taken

Please Initial to indicate your understanding of the following:

_____ I give permission to my Doula to use photos of me and my baby in printed materials. (Each photo will be subject to your approval, and your permission may be revoked at any time.)

_____ I give permission for my Doula to use photos of me and my baby on her website or online social media. (Each photo will be subject to your approval, and your permission may be revoked at any time.)

_____ I understand that photography and video are not my Doula's main focus in the postpartum space.

As your Doula, I commit to keeping your personal information private and will not under any circumstances share that information with anyone. I respect your family's privacy and right to announce the long-awaited arrival of your baby, and will not share any photo or video on any platform or with anyone in person until you have indicated that it is ok for me to do so.

This postpartum photography, video and media release form has been reviewed and agreed to by the following persons as designated by their signatures below:

_____ Date:_____

_____ - Doula

_____

_____

Signatures of Birther (and partner if they have one) Date: _____

Postpartum Doula Evaluation Form

Clients Name:_____

Partners name (if they have one):_____

Length of time services were provided:_____

Baby's Date of Birth:_____(d)_____(m)_____(y)

5 - Strongly agree, **4** - Sort of agree, **3** - Neither agree nor disagree, **2** - Sort of disagree, **1** - Strongly disagree

1. My Doula provided useful communication and information prenatally.....	5	4	3	2	1
2. My Doula provided useful postpartum recovery tips.....	5	4	3	2	1
3. The emotional coping techniques suggested were helpful in handling the first few weeks postpartum.....	5	4	3	2	1
4. My Doula provided support to my partner (If I had one) and enabled them to participate in my recovery.....	5	4	3	2	1
5. I feel that my Doula worked well with the partner and other members of my family/support team.....	5	4	3	2	1
6. The information and education provided by my Doula were up to date and evidence-based pertaining to postpartum recovery.....	5	4	3	2	1
7. The information that my Doula provided was up-to-date and evidence-based pertaining to infant care.....	5	4	3	2	1
8. My Doula was able to provide me with the information and tools I needed in order to make the best decisions for my family.....	5	4	3	2	1
9. The suggestions my Doula made were helpful for my partner and/or other support persons present postpartum.....	5	4	3	2	1
10. My Doula was a useful part of my postpartum support team.....	5	4	3	2	1
11. Overall, my Doula contributed to a postpartum experience positive.....	5	4	3	2	1
12. I would recommend my Doula to others.....	5	4	3	2	1

Postpartum Doula Client Comments

Did your Doula do anything specific that you found helpful during your postpartum period?

Thinking back on your experience with your Doula, what would you have changed? Is there anything you would have wanted more/less of?

Is there anything you feel your Doula could improve in the services that they provided?

Anything you would like to add?

Thank you for taking the time to share your feedback with me! I am committed to reflecting on my client's experiences in order to improve my practice, build on my skills, and grow as a Doula.