Client Information and Consent Form

Cygnus Lactation Services ~ Please print clearly, thank you!

Mother's Information

Full Name:_____ **D.O.B.** _____ **Occupation:**_____ **Phone:**_____

Address:_____ **City, State, Zip:** _____ **Alternate Phone:** _____

Mother's Physician: OB ☐ **Primary Care** ☐ **Other** ☐ _____ **Phone:** _____ **Fax:** _____

Practice Name:_____ **Practice Location:**_____

Preferred Method of Communication: Phone ☐ **Email** ☐ **Text** ☐ **(9am-9pm)** **Permission to leave information on voicemail? Yes** ☐ **No** ☐

Whom else may we share your information with? Full Name:_____ **Relationship:**_____

I have been approved by the Ashland Health Lactation Network for 100% coverage of this visit. Yes ☐ **No** ☐

Name of Insurance Company (if applicable) _____ **Signature:** _____ **Date**: _____

Insurance Release: I authorize the undersigned health care provider to release any information acquired in the course of my examination or treatment. Payments for services are made at the time of your appointment. We are happy to submit a claim for reimbursement but cannot guarantee payment from your provider. If your claim is accepted you will be paid directly by your insurance company.

E-mail Address:_____ **Would you like to receive event notices? Yes** ☐ **No** ☐

Would you like to join our private Facebook group? Yes ☐ **No** ☐ **Who may we thank for referring you to our practice?** _____

Partner's Information

Full Name:_____ **D.O.B.** _____ **Occupation:**_____ **Phone:**_____

Infant's Information

Full Name:_____ **D.O.B.** _____ **Sex:**_____ **Birth Weight:** _____**Lbs** _____**Oz**

Place of Birth: _____ **Hospital City, State:**_____ **Infant's Physician:**_____

Phone: _____ **Fax:** _____ **Practice Name:**_____ **Location:**_____

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. Phone contact during the time following the lactation visit is crucial and considered an extension of your visit. You will be given 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 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 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. .2

☐ 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. (This sheet is in your membership folder)

☐ I understand this practice only accepts fees for service at time of service. It is my responsibility to pursue reimbursement for lactation services.

☐ I understand that if I am given a loner pump or scale that I will not be charged for one week. If it is not returned on the agreed upon date I will be charged the daily rental fee until it is returned.

☐ I understand that a Telehealth visit is not to be used in place of an in-person visit for serious lactation issues

☐ I understand that Cygnus Lactation Services is a teaching clinic and interns may be present at my appointment

Signature: _____ **Date:** _____