Hope Breastfeeding Support

Intake, Consent and Financial Responsibility Acknowledgement Form

Mom: _____ Mom's Birthdate _____ Dad: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Other Contact Info: _____

How would you prefer to be receive report from this consult? ☐Email ☐ Regular Mail☐ Fax_____

Referred by ☐ Friend/Family _____ ☐ Hospital _____ ☐ Doctor: _____

Other: _____

Baby's Full Name: _____ Date of Birth: _____ Due Date: _____

Delivering Health Care Provider: _____ Fax Info: _____

Baby's Health Care Provider: _____ Fax info: _____

I understand that:

- All that all medical care is provided by my own health care providers and that any change from their recommendations should be discussed with them.
- A lactation consultation provided by an IBCLC may include visual and manual assessment of the mother's breasts and infant's body including a digital suck assessment, observation of the mother and baby breastfeeding, analysis of information given regarding the breastfeeding situation, demonstration of techniques and positions to improve breastfeeding efficiency, use of breastfeeding equipment and a recommendation of a care plan to resolve any breastfeeding issues. These recommendations may be adjusted during the course of treatment.
- A student intern may accompany the IBCLC and participate in the consultation for training purposes.
- I am responsible for informing the lactation consultant of any relevant information or changes that may affect the breastfeeding situation
- *It is my responsibility to contact the lactation consultant with progress reports, questions or concerns.*
- **Payments for services and supplies are my sole responsibility and required at the time of service. A receipt will be provided for insurance reimbursement.**

I grant consent for:

- Information about this consultation to be mailed, faxed or emailed to my baby's and my attending healthcare providers. **I understand that email communications may not be fully encrypted.**

Int. ___.

- Information from this consultation may be used for teaching purposes, provided no names or identifying features will be used.
- Treatment according to the scope of practice outlined above.
- Communication between myself and the consultant may be conducted through email or texting now and in the future.
- **My signature below acknowledges my understanding and acceptance of the conditions set forth above.**

_____ _____

Client Signature **Date**