Sabrina Freidenfelds, MPH, IBCLC
INTERNATIONAL BOARD CERTIFIED LACTATION CONSULTANT
Then Comes Baby, LLC

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LACTATION CONSULTATION CONSENT FORM

MOTHER

Your Name _____ Your Birth Date ___|___|___ Your Age _____ Your Profession _____

Street Address _____ City _____ State _____ Zip _____

Partner's Name _____ Partner's Profession _____ Best phone to reach you: ◉ Home/Landline ○ Cell

Phone (home/landline) _____ Phone (cell) Do you text? ◉ Yes ○ No _____ Email _____
Note that text messages are not secure and cannot protect your private health information (PHI)

How would you prefer to receive the report from this consult? ☐ Email ☐ Regular Mail ☐ Faxed To: _____

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

Website: ☐ _____ ☐ Internet search ☐ Other referral source: _____

BABY

Baby's Full Name _____ Sex: ○ M ◉ F Due Date ___|___|___ Birth Date ___|___|___ Weeks Gestation at Birth _____

Place of Birth _____ City/State of Birth _____

INSURANCE

Insurance Company _____ Primary Insured's Name _____

Employer _____ Date of Birth ___|___|___ ◉ Self ○ Spouse ○ Other Relationship to Mother

Member Number: _____ Group Number: _____

HEALTH CARE PROVIDERS

OBSTETRICIAN / MIDWIFE

Diana West
Name Send report? ◉ No ○ Yes (provide following info):

City and State _____

Phone _____

Fax or Email _____

PEDIATRICIAN

Name _____

City and State _____

Phone _____

Fax or Email _____

I understand that:

- All medical care is to be provided by my own physician(s) and that any change from his/her/their recommendations should be discussed with him/her/them.
- A lactation consultation by the IBCLC may include a visual and manual assessment of the mother's breasts, the baby's mouth and suck, observation of the mother and baby breastfeeding, analysis of information relating to the breastfeeding situation, demonstration of techniques for improving breastfeeding, use of breastfeeding equipment, and recommendation of a care plan to resolve breastfeeding issues, which 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(s) of any relevant information or changes that affect my breastfeeding situation.
- *It is my responsibility to call the lactation consultant(s) with progress reports, questions, or concerns.*
- This practice will submit a claim for direct payment of insurance benefits with participating insurance companies and bill me for any remaining co-pay or fees. For those who are not insured or who are insured with companies with which we do not participate, payment 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 attending physician/health care providers.
- The release of any medical information necessary to process any insurance claim(s) and payment of any insurance benefits directly to this practice.
- Information from this consultation to be used for teaching purposes, with the understanding that no names or identifying features will be used.
- Treatment according to the scope of practice outlined above.

My signature below acknowledges my understanding of the conditions set forth above.

_____ _____
Client Signature Date

_____ INITIALS

I give permission for photos and/or videos of my lactation visit to be taken and used solely for educational purposes, including presentations at professional conferences and workshops without further notice or compensation. No identifying information will be present in any photograph or video.