GentleBirthOptions LLC

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Lactation Consent

_____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 this visit. I understand I 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 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 only fee for service at time of 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. Reimbursement is not guaranteed, but filing is suggested.

_____ I give permission for information, photos and/or videos of my lactation visit to be used in lactation articles or studies for professional education.

Signature_____

Date_____