Kimberly Rush Mothering Support Service

Mother's First and Last Name _____ DOB _____

Consent Agreement to be READ, INITIALED & SIGNED before the Lactation Consultation

_____ 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, and may involve the following assessment and/or treatment services, including but not limited to: touching my breasts and/or nipples for the purposes of assessment; inserting gloved fingers into my baby's mouth to assess suck and oral cavity; observation of a feeding for evaluation of technique and effectiveness of feeding, and suggestions to enhance latch or position; demonstration of the use of equipment or supplies that may be recommended, and demonstration of techniques designed to improve breastfeeding. 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 grant my permission for breastfeeding consultation services.

_____ 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 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, 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 give my consent for the lactation consultant to use clinical information obtained during our sessions for education of other health care providers and other mothers/clients about lactation. I understand that my baby and I will not be identified in any way, but that details and / or other aspects of our situation might be described and discussed.

_____ I understand this practice will file a claim with my insurance company for the consultation without a prior authorization from my insurance company for the lactation visit. This practice does not guarantee insurance reimbursement. I am aware and agree that if the above insurance company does not pay the claim, I agree to pay the Kimberly Rush the billable amount upon receipt of the lactation invoice. I realize that the lactation consultant will not know if the insurance company denies the claim until it is submitted and therefore may not send me an invoice until up to 12 months after the lactation consultation.

_____ I give permission for photographs and audio and/or visual recordings to be made, of both my baby and me, for charting and clinical/education purposes. If the photographs are shared in a clinical or educational context identifying features or information will not be shown.

_____ I agree to have communications about my case be sent by email/text. I understand that this is not a secure or encrypted means of communication, and the materials may contain protected health information (PHI).

_____ I understand that for this lactation consultation and all follow-ups, Kimberly Rush, BSN, RN, IBCLC, will protect the privacy of my personal health information as required by the Code of Professional Conduct of the International Board of Lactation Consultant Examiners (IBLCE), the IBLCE Scope of Practice for IBCLCs, the Standards of Practice of the International Lactation Consultant Association, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have received a copy of this provider's Privacy Practices which is located on the practice website KimberlyRush.com.

Mother's Signature_____ Date_____

Lactation Consultant's Signature _____ Date _____