Mahala
Lactation and Perinatal Services, LLC

LACTATION CONSULT INTAKE & CONSENT FORM

Your Name _____ DOB _____ Age _____ Employer/Profession _____

Street Address _____ City _____ State _____ Zip _____

Partner's Name _____ Partner's Profession _____ Best way to reach you ☐ call ☐ text ☐ email

Phone (home) _____ Phone (cell) _____ Email _____

Referred by: ☐ friend/family: _____ ☐ hospital: _____ ☐ doctor: _____

Website: ☐ ILCA ☐ Facebook (group)_____ ☐ Google search ☐ lowmilksupply.org ☐ other _____

Baby's Full Name _____ sex: ☐ m ☐ f DOB (m/dd/yy) _____ Weeks Gestation at Birth _____

Place of Birth _____ City/State of Birth _____

Insured's Name _____ DOB _____ Employer _____ ☐ self ☐ spouse ☐ other Relationship to mother

Insurance Provider _____ Group # _____ ID # _____

PRIMARY CARE (MOM)	OB/MIDWIVES	PEDIATRICIAN
Name	Name	Name
City/State	City/State	City/State
Phone	Phone	Phone
Fax	Fax	Fax

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 related 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 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 may affect my breastfeeding situation.
- It is my responsibility to contact the lactation consultant(s) with progress reports, questions, or concerns.
- This practice (Primary Care Partners LLC) will submit a claim for services for direct payment of insurance benefits on behalf of both mother and baby. Copays are due at time of visit. Deductibles and coinsurance are your responsibility and will be billed to you by our office if applicable. If we do not participate with your insurance company, you will be responsible for payment upfront at the time of your visit. Please call your insurance company with any questions.

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 _____

☐ I give permission for photos and/or video 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. **Please initial:**

HIPAA ACKNOWLEDGEMENT

Notice of Privacy Practices

Print name of patient: _____

Patient DOB: _____

We at Primary Care Partners LLC/Mahala are required by law to maintain the privacy and provide individuals with access to the notice of our legal duties and privacy practices with respect to protected health information (PHI). I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document and understand that I may obtain a copy for my records upon request.

Signature of patient/legal representative: _____

Today's date: _____

Email address of patient/legal representative: _____

Phone number of patient/legal representative: _____