Julie Alexander
Lactation Support

Consent Form

The lactation consultant is an allied health care provider and responsible for evaluating and recommending a plan of care to resolve or improve breastfeeding issues.

By reading and signing this Consent Form you authorize Julie Alexander BA, IBCLC (lactation consultant) to do all of the following:

- A lactation consultation may include:
  - Visual and physical assessment of the mother's breasts
  - Visual and physical assessment of the infant's mouth
  - Observation of the mother and infant nursing
  - Analysis of the data relating to the breastfeeding situation
  - Demonstration of techniques for improving breastfeeding
  - Sometimes the use of breastfeeding equipment

- I understand that I am responsible for informing the lactation consultant of changes I feel are necessary to the plan of care at the time of the visit or during the course of follow-up communication. Email/phone contact during the two weeks following the consultation is crucial and considered an extension of this visit.

- 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 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 that the lactation consultant will send a doctor's report to my attending physician or other health care providers.

- I understand that follow-up visits are sometimes necessary and cost $60 per visit.

- I understand that I may need to acquire breastfeeding supplies or equipment as recommended in the patient's plan of care. Only effective breastfeeding equipment will be recommended.

- I give consent to the lactation consultant to use clinical information and photographs or video obtained during our consultation for conferring with other health care providers and education of mothers about lactation. I won't be identified in any way, but aspects of my situation may be described and discussed. I acknowledge that these photos and videos are the property of the lactation consultant.

- I have received a paper/electronic copy of Julie Alexander Lactation Support HIPAA Privacy Practices. Available online at https://jalactation.com/forms/hippa.pdf

  Initial _____

- I understand I will be given an email address and phone number to call or text to report progress or to communicate continued problems or concerns. I understand that electronic or cellular forms of communication may not be encrypted or secure and that the lactation consultant cannot guarantee privacy when using cellular communications.

- I understand that payment is due at the time of services rendered. This practice does not bill for insurance reimbursement and is not a provider of any insurance plan. An insurance superbill will be provided to you to submit to your insurance company. It is my responsibility to pursue reimbursement for lactation services from my insurance company.

_____	_____
Mother's Signature	Lactation Consultant's Signature
_____	_____
Mother's Name	Lactation Consultant's Name
_____	_____
Date	Date