Wendy K. Hall, BSN, RN-C, CLC
Mother's Milk Lactation, LLC
MothersMilkLactation2022@gmail.com
(228) 236-5608
12346 White Oak Ct Gulfport, MS. 39503
facebook.com/MothersMilkLactationLLC

Consent and Agreement for Lactation Services

Please read the text below carefully as your signature below represents your consent and agreement to the text.

Client Information ▼

Parent Information

Name:

Email:

Phone:

Infant(s) Information

Name:

Name:

Name:

Provider Information ▼

OBGYN / Midwife

Name:

Phone:

Pediatrician

Name:

Phone:

Family Practitioner

Name:

Phone:

Chiropractor

Name:

Phone:

Other Provider

Credential:

Name:

Phone:

★ Interested in helping build my lactation practice with promotional and/or education material? ★

My signature below is my written permission for photos and/or videos documenting any lactation related specifics to be taken during our visit and used for educational and marketing materials. Identity will be protected and names will not be disclosed. Compensation will not be granted for use of the materials.

X_____

- I understand the lactation professional is not a clinician with authority to diagnose any condition or illness or to prescribe any medication.

- I understand that a visitation may include the following: detailed intake of parent and infant(s) which includes questions based on health history and current and past experiences pertaining to lactation, weighing infant(s), observation of a complete feeding, and a brief assessment of the parent breast/chest and infant's oral abilities. The lactation professional may ask consent to touch my infant and/or my breast/chest.

- I understand that suggestions will be given written and/or verbal. The lactation professional does not take liability for any breast/chest feeding outcomes and all decisions and actions made based on suggestions given are solely mine and only mine.

- I understand a follow-up visit may be necessary and it is up to the discretion of the lactation professional to decide the need for virtual or in-person based on circumstances of my own lactation needs. Concerns are not expected to change immediately and I understand that it may take time and adjustments to suggestions previously made before results are seen.

- I understand it is my responsibility to contact the lactation professional over the *secure portal* of choice with updates on progress, questions or concerns that I am having.

- I authorize the lactation professional to release any information acquired during the lactation intake and visitation about myself and/or my infant(s) to our listed health care providers and/or our insurance company. I allow contact with our health care providers as it may be considered an extension of the lactation visit.

- I understand the lactation professional does not accept late payments. Payment is due in full at the time of service.

- I understand that it is my responsibility to submit any billing or invoice to my insurance company or my infant('s) insurance companies. I will not be refunded for the lactation visit if insurance does not cover lactation benefits.

- I understand that the lactation professional will counsel me to the best of their abilities based on the tools and information that is available to them and within their scope of practice. Referrals may be necessary and instructed.

- I have signed and understand the lactation professional's HIPAA Privacy Practices. A copy may be requested at any time.

Please sign below if you are in agreement to terms listed above.

Date:	Signature:

Consent to Lactation Services Form © Joleen Bice 2021