Consent for Lactation Consultation

I hereby give my consent for Leslie Stern, [International Board Certified Lactation Consultant ["IBCLC"] and associates of Beyond Birth Lactation Services, to offer professional services with respect to my child/baby and me for a consultation regarding my breastfeeding problem/concern. This consent shall cover all in person, face-to-face visits and all follow-up in person contacts; it shall also include phone conversations, and information sent via the Internet, fax, email, or regular mail pursuant to the described parameters and actions detailed more fully below.

I understand that Leslie Stern is a certified IBCLC in the state of NC and will provide care and for me as an IBCLC, not a Certified Nurse Midwife ["CNM"].

I understand that a lactation consultation 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 breastfeed, 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.

I give my consent for Leslie Stern, IBCLC, and associates to contact my baby's and my health care provider(s) with a report of our consultation, as the ethics of her profession require, and to consult with them in any way she deems appropriate. I give my consent for Leslie Stern, IBCLC to release pertinent information to my insurance company, as necessary.

I give my consent for Leslie Stern, IBCLC 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 agree and consent to allowing Leslie Stern to discuss my case with, and forward my contact information to a breastfeeding support group counselor, Midwife, or my doula, if I have one. _____ Initial here

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. _____ Initial here

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]. _____ Initial here

I understand that total payment is expected at the TIME OF the consultation. I will receive paperwork to submit to my insurance company for consideration of reimbursement. In the event of a co-pay for services rendered for Mom or Baby, I agree to pay.

I understand that for this lactation consultation and all follow-up, Leslie Stern, 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, 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 the Notice of Privacy Practices of the lactation consultant.

_____/_____/_____
If Mom agrees (consents), signature here Date

_____/_____/_____
Lactation Consultant signature here Date