HEALTHY BEGINNINGS
Lactation LLC

Release/Consent Form

A lactation consultation usually includes 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, and sometimes the use of breastfeeding equipment. I give permission for the lactation consultant to do all of the above.

I understand that all medical care is to be provided by our physician(s). I give my permission for information about this and all additional consultations to be sent to my attending physician(s)/health care provider(s).

With the exception of Aetna subscribers, I understand that total payment for this consultation is expected at the conclusion of this visit. I understand I will receive paperwork to submit to my insurance company for consideration of reimbursement. I give my consent for the lactation consultant to release pertinent information to my insurance company, as necessary.

For Aetna Patients only:

I understand any portion of my bill that is not paid by the insurance for any reason is then my responsibility. I do authorize direct payment from Aetna to Healthy Beginnings Lactation. Aetna plans with the women's preventative services benefit cover up to six visits with a lactation consultant. Some plans are not subject to the women's preventative breastfeeding services requirements under the Affordable Care Act (also known as the Health Care Reform Law) which includes plans that are "grandfathered" or otherwise exempt. These plans may not include all of these benefits or there may be different member cost-sharing on certain benefits. Employers with "grandfathered" plans may choose not to cover some of these preventative services or to include cost share such as a deductible, copay, or coinsurance and you can contact your HR department for additional information.

I give my permission for information from this consultation/visit to be used to further the knowledge of breastfeeding. I understand that no specific names will be publicly used. I give permission to Healthy Beginnings Lactation to photograph or videotape myself and/or my infant(s). I acknowledge that these images belong to Healthy Beginnings Lactation and our intended use for these images is for the education and promotion of breastfeeding and lactation counseling.

I understand that I have the right to refuse any or all specific techniques suggested, equipment to assist or remedy breastfeeding problems, and/or all recommended actions. Healthy Beginnings Lactation will provide names of other qualified providers of lactation consultant services or equipment upon request.

_____ _____

Mother's Signature Date

_____ _____

Lactation Consultant's Signature Date