Erica Diehl, IBCLC

CONSENT

- I give my consent for the lactation consultant to work with me and my baby during this consultation and for my breastfeeding problem/concern. This consent is for in-person visits, as well as telephone conversations, and any information sent/communicated via email, mobile phone, fax, SMS text messages, and/or private social media. I understand that electronic/cellular forms of communication may not be encrypted/secure.
- I understand that a lactation consultation may involve: touching my breasts and/or nipples for the purposes of assessment; inserting gloved fingers into my baby's mouth to assess suck; 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 understand that I am responsible for informing the lactation consultant of changes that I feel are necessary in the care plan at the time of the visit or during the course of follow-up communications. Contact during the time following the lactation visit is crucial and considered an extension of my visit. I will be given a phone number to call to report progress or to communicate continued problems or concerns. I understand it is my responsibility to call the lactation consultant with progress reports, questions, or concerns.
- I give my consent for 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 the lactation consultant may contact my physician or my child's physician if the lactation consultant feels it is necessary to consult with the physician.
- I give my consent for the lactation consultant to use clinical information and photography/video obtained during our sessions for conferring with another health care providers and private client education. I won't be identified in any way, but aspects of my situation may be described and discussed.
- I understand that total payment is expected at the conclusion of the consultation. I will receive an invoice to submit to my insurance company for consideration of reimbursement. I also understand that Erica Diehl, IBCLC does not give refunds for services rendered.
- I understand that for this lactation consultation and all follow-ups, the lactation consultant will protect the privacy of my personal health information as required by the Code of Ethics of the International Board of Lactation Consultant Examiners, 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 this provider's Notice of Privacy Practices.
- I understand that a student lactation consultant may be present to observe my consultation.

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If client agrees (consents), signature here *Date*

PERMISSION TO TAKE/USE PHOTOGRAPHS/VIDEO

- I give permission for Erica Diehl, IBCLC to photograph or videotape myself and/or my infant(s).
- I acknowledge that these images belong to Erica Diehl, IBCLC and that the intended use of these images is for referral charting, professional conferring, and private client education.
- I permit these photographs/videos to be used for the above-stated purposes.
- I understand that I will not receive further notification or compensation when these images are used.

_____ _____

If client agrees (consents), signature here *Date*