Healthy Babies Inc
8267 W. Golf Rd., Niles, IL 60714
Lactation Consultation Registration Form

LC File # _____
Pump File # _____

Date: _____

Mom's Last Name _____First _____Birth Date_____

Baby's Last Name _____First _____Birth Date_____M / F

Address:_____

Phone: Home:_____ Cell: _____ email:_____

Mom's Profession / Employer _____

Dad's Last Name _____First_____

Dad's Profession / Employer _____

Baby's Physician: _____Phone/Fax_____

Mom's Physician: _____Phone/Fax_____

Mom's Insurance_____ID#_____Group#_____

Baby's Insurance (if different) _____ID#_____Group#_____

Subscriber: _____ Birth date_____

Referred By: _____Phone/Fax_____

Consent for Lactation Consultation
Please read, initial each statement, and sign at the bottom

☐ I hereby give consent for healthcare professionals / Lactation Consultant (LC) affiliated with Healthy Babies Inc. to provide me and my baby/babies breastfeeding related services which include any or all of the followings: detailed history taking of mother and infant, hands on assessment, observation and assistance during feeding, instruction and demonstration of the use of a breastpump or other equipment, and provides oral/written recommendations for the management of breastfeeding issues.

☐ I understand Breastfeeding success depends on several factors and is not guaranteed by this consultation. Resolution of breastfeeding problem often takes several days or weeks and may require changes in the original recommended care path. I understand it is my responsibility to call the LC with progress, questions, or concerns

☐ I understand any changes with my physician's / Primary Care Provider (PCP) recommendations should be discussed with the physician. Health issues of medical nature must be discussed with a physician / Primary Care Provider (PCP).

☐ I hereby authorize the LC to release any information regarding this consultation to our health care providers, referring physician, and or insurance company upon request. I understand the LC may contact our Healthcare provider if necessary.

☐ I received a copy of Healthy Babies Happy Families Notice of Privacy Practice (www.healthybabiesinc.com)

☐ I authorize Healthy Babies Inc to bill directly and accept payment from my health insurance carrier if I am eligible. Claims will be on Mom's and infant's name for services involving both. Additional charges for equipments or supplies may require as needed.

Signature_____ **Date**_____