Uyen Tran, MBA, CLC
NPI # 1992476295
CLC # 332464

Marigold Lactation
Half Moon Bay, CA 94019
(510) 292 7758
uyen@marigoldlactaiton.com
marigoldlactation.com

LACTATION SERVICE CONSENT FORM

PARENT

Your Name | Your birthday | Your Age | Your Profession

Street Address | City | State | Zip

Partner's Name | Parter's Profession | Best phone to reach your ☐ Home ☐ Cell

Home Phone | Cell phone | Email

Note that text and email messages are not secure and cannot protect your private health information (PHI)

How would you prefer to receive the report from this consult? ☐ Email ☐ Regular Mail

Referred by ☐ Friend/ Family _____ ☐ Hospital _____

☐ Doctor _____ ☐ Internet search _____

☐ Other referral source _____

BABY

Baby's Full Name | ☐ Male ☐ Female | Due Date | Birth Date | Gest. Age

Place of Birth | City/ State of Birth

HEALTH CARE PROVIDERS

OBSTETRICIAN/ MIDWIFE	PEDIATRICIAN
Name	Name
Send report ☐ No ☐ Yes (provide info)	
City and State	City and State
Phone	Phone
Fax or Email	Fax or Email

* I hereby give my written consent for Uyen Tran to work with my baby and me during this and subsequent counseling sessions for my breastfeeding problem/concern. I understand that this consultation may involve

Touching my breasts and/or nipples for the purposes of assessment

CONTINUE TO PAGE 2

Performing an oral digital examination on my baby in order to assess the suck

Observation of a breastfeed, and demonstration of techniques

Use of equipment that may be necessary to improve breastfeeding

Recommendation of a care plan to resolve breastfeeding issues, which may be adjusted during the course of treatment

* **I understand that I am responsible for informing Uyen Tran of changes I feel are necessary in the plan of care at the time of the visit or during the course of follow up communications. I understand it is my responsibility to call Uyen Tran with progress reports, questions or concerns.**
* I understand that follow-up visits are sometimes necessary.
* I give my written consent for Uyen Tran to send any and all pertinent information to my infant's and my primary health care providers, and to consult with them in any way she deems appropriate.
* I give my written consent for Uyen Tran to communicate with my health care professional and/or insurance company via mail, e-mail or fax.
* I give my written consent to leave voice mail/text/email messages. I understand that none of the above are encrypted. Verbal messages may also be left with anyone who answers the phone and that Uyen Tran cannot guarantee privacy when using cellular communications.
* I give my written consent for Uyen Tran to use clinical information obtained during these sessions to be used for education of other health care providers about lactation.
* I give permission for photos and/or videos of my lactation visit to be taken and used solely for educational purposes, including presentations at professional conferences and workshops without further notice or compensation. No identifying information will be present in any photograph or video.
* **I understand that payment for services and supplies are my sole responsibility and required at the time of service. This practice does not bill for insurance reimbursement and is not a provider of any insurance plan. A Superbill will be provided to me to submit to my insurance company. It is my responsibility to pursue reimbursement for lactation services from my insurance company. If your insurance company remits payment to Uyen Tran, she forward the funds to me.**
* I understand that refunds cannot be issued after services have been rendered.

My signature below acknowledges my understanding of the conditions set forth above.

_____ _____

Client Signature **Date**