Intake Form

MILK & HONEY

Baby's Name: Last _____ First _____
DOB: _____ Age _____ Gestation _____
Sex _____ Birth weight _____ Current weight _____

Mom's name: Last _____ First _____
Age DOB Occupation

Partner's name: Last _____ First _____
Age _____ DOB _____ Occupation _____
Address _____Zip_____

Phone number(s) ( ) _____
Email:_____
Primary Insurance:_____
Secondary Insurance: _____

Referred by_____
Pediatrician _____
OB/Midwife_____

Why have you requested this consultation?

☐ Infant not latching on to the breast ☐ Mother nipple pain
☐ Infant having difficulty latching
☐ Infant weight gain problem ☐ Maternal low milk supply
Other reason(s) _____

I grant permission to Milk and Honey, LLC to share pertinent information about this consultation with our family physicians and healthcare providers, the referring person(s), our community breastfeeding helper, and/or our insurance companies, to further the knowledge of breastfeeding. I also acknowledge that my IBCLC/Feeding Therapy may share pertinent information with other providers of Milk and Honey if necessary to collaborate and/or discuss as case studies. I understand that all medical care is to be provided by our own physicians.

___/___/___ _____ ___/___/___ _____
date signature of mother/father date signature of provider

☐ By checking this box, I am acknowledging that I am electronically signing this form.

Email/Text Correspondence

My lactation consultant (IBCLC) and/or feeding therapist may choose to send a text or email to set up an appointment, confirm an appointment, or follow up after a session. I am aware that if I choose to accept texts and/or emails, or if I send questions and updates via text or email, that these forms of correspondence are not a secure (encrypted) form of correspondence.

I can choose to respond via text or email, but conversations via text will be kept as brief as possible. If I have more in depth medical or personal questions, it is recommended to me to call my IBCLC/feeding therapist. My IBCLC/feeding therapist may also feel that a phone conversation is more appropriate for the situation.

I, _____ (Parent/Guardian/Client), hereby authorize "Milk and Honey, Feeding and Speech Services, LLC" to correspond with me via e-mail or text message using the following information:

E-mail _____

Cell Phone_____ Phone Messages (detailed) Yes/No

Signature_____ Date _____

Printed name: _____

☐ By checking this box, I am acknowledging that I am electronically signing this form.

Milk and Honey,
Specialized Breastfeeding and Postpartum Support Center
Milk and Honey, Feeding and Speech Services, LLC

Notification of Rights and Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal law designed to protect your privacy whenever your healthcare providers have to discuss your case, or send information about you to different offices. We have to keep a file or record of our consultations/sessions, but we promise that the private, protected health information (PHI) in it will be kept confidential. Milk and Honey can freely share all the details of your personal health information for purposes of "treatment, payment and healthcare operations." That means Milk and Honey can talk to you about your situation, and discuss it with your other healthcare providers. If you are referred to other specialists, Milk and Honey can send or discuss the information to them. Milk and Honey can also share the information with your health insurance company if needed.

The law also requires Milk and Honey to share your information under other, very precise situations; for example, if a subpoena has been served to turn over medical records, or a federal agency is investigating a complaint that we have not been protecting your privacy.
Any other time Milk and Honey shares your personal health information, It has to be with your specific written authorization.

You have 4 rights under HIPAA:

1. Access (You can ask Milk and Honey for your PHI);
2. Amendment (You can ask Milk and Honey to change their files to amend inaccurate PHI);
3. Disclosure Accounting (You can ask to whom Milk and Honey as given your PHI) and
4. Restriction Request (You can put limits on Milk and Honey's use and sharing of your PHI)

Client Rights
It is you and your child's right:

1. To be treated with respect for personal dignity and need for privacy regardless of race, color, religion, sex, age, physical or mental limitations or national origin.
1. To participate in decisions involving treatment or the plan of care.
2. To reasonably access Milk and Honey's services and information regarding financial charges for which you are responsible.
3. To express an inquiry/complaint or file an appeal and expect an answer to this inquiry, complaint or appeal within a reasonable period of time.

I have read the above information and am aware and have been notified of my personal rights in addition to Milk and Honey, LLC privacy practices.

_____

Signature of Consenting Party Date

☐ By checking this box, I am acknowledging that I am electronically signing this form.

Release and/or Request of Medical Information

Parent/Guardian name: _____ Date of birth: _____

Child's name: _____ Date of birth: _____

Please only release or request relevant medical documentation from/to the following:

Child's Pediatrician & Practice Name: _____

Mother's OB/GYN & Practice Name: _____

Specialist Physician/Practice: _____

Specialist Physician/Practice: _____

Specialist Physician/Practice: _____

Other: _____

Other: _____

Is Milk & Honey authorized to leave detailed phone messages to any of the physicians listed above?
☐ Yes ☐ No

My signature authorizes Milk & Honey LLC to release and/or request medical and treatment information regarding me or my child from the providers and organization listed above.

Signature: _____ Date: _____

Print name: _____

☐ By checking this box, I am acknowledging that I am electronically signing this form.

Milk and Honey
Specialized Breastfeeding and Postpartum Support Center
Agreement to Pay for Professional Services

1. I request that Milk and Honey provide professional services to me and/or my child and I agree to pay their fee of $ _____ for the initial consultation and $_____ for follow-up sessions, and/or a co-pay/co-insurance amount of $_____, if applicable when I am using insurance. _____ (Initial)
2. I acknowledge that a verbal pre-authorization is not a guarantee of payment in full by my insurance company. I agree to pay any and all uncovered services rendered. _____ (Initial)
3. I agree to inform Milk and Honey if my insurance coverage lapses or changes. If I fail to inform Milk and Honey of any potential changes in my coverage, I acknowledge that I am responsible for all and any charges. _____ (Initial)
4. I also understand that, when submitting to insurance for services provided by Milk and Honey:

☐ I may have an annual deductible, and that deductible may zero out each New Year (actual date may vary by insurance carrier). _____ (Initial)

☐ Fees for services provided by Milk and Honey may or may not be (fully or partially) covered and/or applied to my deductible. _____ (Initial)

1. If I am using insurance, I understand that Milk and Honey will make their best effort to help me find out what my health coverage is and help me with necessary authorizations, etc., but that ultimately I am responsible for payment for all uncovered expenses. _____ (Initial)
2. I agree to pay with check or cash or credit card. _____ (Initial)
3. I agree to pay $25.00 for any returned checks. _____ (Initial)
4. I agree to pay a missed session fee of $50 if I do not show up for my scheduled appointment or if I cancel my appointment with less than 48 hours notice. I understand that insurance companies do not pay for missed sessions. I understand that if there are extenuating circumstances, Milk and Honey may choose to waive the missed session fee on a case-by-case basis. _____ (Initial)
5. I have also read Milk and Honey's Rights and Responsibilities form and agree to act according to everything stated there, as shown by my signature below and on that form. _____ (Initial)

_____ _____

Signature of Parent Date

_____ _____

Signature of Consultant/Therapist Date

☐ By checking this box, I am acknowledging that I am electronically signing this form.

Milk and Honey LLC
Photo & Video Release

MILK & HONEY
SPECIALIZED BREASTFEEDING AND POSTPARTUM SUPPORT CENTER

Child name _____

Parent name _____

Parent address _____

Phone _____

Email Address _____

Please initial all appropriate:

- Milk and Honey permission to use my and/or my child's photo for/on:
  - Training presentations (including, but not limited to: Milk & Honey in-services & training, University presentations at Universities, medical schools, & other organizations, industry professional presentations, etc.) _____
  - Cross-training providers _____
  - Brochure/Marketing materials _____
  - Website _____
  - Framed pictures in the office _____

The undersigned authorizes Milk and Honey, LLC to reproduce the materials described above in connection with print publications and audiovisual programs of the above entities. Such materials may be published, reproduced, exhibited, or used in the ways specifically listed above.

Signature of parent/guardian: Date:

_____ _____

I am the child's parent or guardian and I agree to the above on behalf of the child.

_____ _____

Signature, Milk and Honey, LLC Date

☐ By checking this box, I am acknowledging that I am electronically signing this form.