Betsy's Baby Services

INTAKE FORM AND GENERAL CONSENT FOR
INTERNATIONAL BOARD CERTIFIED LACTATION CONSULTANT SERVICES

Baby's Last Name	Baby's First Name
Today's date	
Baby's Age	Baby's Date of Birth
How long was your pregnancy? *(for example, 36 weeks)*	Baby's sex/preferred pronoun
Baby's Birth Weight _____lb. _____oz.	Discharge Weight _____lb. _____oz.
Current Weight (if known) _____lb. _____oz.	

Client (birth parent) information	Preferred pronouns:
Client's Last Name	First Name
Date of Birth	Age
Occupation	
Street Address	City/State/Zip
Cell Phone	Email address

Parent 2 info (if applicable)	**Fill out parts that are different from parent 1**
Parent 2 Last Name	Parent 2 First Name
Date of birth:	Preferred pronouns:
Cell Phone	Email address

Pediatrician name/clinic:	Name and practice name of whoever is doing postpartum care of client (midwife, OB, GP):
Referred By:	
Insurance company (if Aetna, provide copy/photo of card):	

Why have you requested this consultation?

6048 26th Ave SW Seattle WA 98106 • 206-353-9334 • betsy@betsysbabyservices.com
www.betsysbabyservices.com • Fax: 888-817-4713

Betsy's Baby Services

I give my **consent** to Betsy Hoffmeister, MPA, IBCLC of Betsy's Baby Services to observe me breastfeeding, to perform basic, non-invasive examination of the baby, and/or to examine my breasts during the period of lactation assistance. I grant permission to Betsy Hoffmeister, Betsy's Baby Services, to share pertinent information about this consultation with my/our family physicians and health care providers, the referring person, my/our community breastfeeding helper, my/our insurance companies (upon my request) and to further the knowledge of breastfeeding. I/We understand that all medical care is to be provided by my/our own physician(s). I am not affiliated with any hospital, clinic, or other care provider but I will communicate with your care provider(s).

Most visits take at least two hours. Service is provided for a fee at the time of my visit. I charge $210 per visit. Follow up visits are $125. There may be a surcharge for travel outside of the Greater Seattle Area. Extra items like parking, breastfeeding tools etc. are additional. I charge on a sliding scale. However, if the fee is beyond your ability to pay, I will only charge what you are able to pay. I also accept payments in installments. Please let me know what is a comfortable fee for your family.

I accept checks, cash, credit cards, and Health Savings Account/Family Savings Account cards. I will give you a "Superbill" you can submit to your insurance. I am a preferred provider with Aetna.

_____ _____

Date Signature of Client (digital signatures apply)

I give consent to Betsy Hoffmeister, MPA, IBCLC of Betsy's Baby Services to photograph me, my bare breasts, my baby, the contents of my baby's diaper, or other clinically relevant parts of the lactation visit. Photos may be shared only with other IBCLCs or with my pediatrician or obstetrician to obtain input and information about possible clinical situations.

_____ YES
_____ NO

I give consent for Betsy Hoffmeister, MPA, IBCLC of Betsy's Baby Services to use my photo in promotional material, including her website or marketing materials.

_____ NO, are you kidding me?
_____ YES, if I get to approve the photo first.
_____ YES, without me seeing it.

_____ _____

Date Signature of Client (digital signatures apply)

Regarding electronic communication: most of my clients like to communicate via email and text. I need you to know that e-communication is NOT secure. If my cell phone were to get lost, your information would be lost with it. Anyone can access e-communication along with your personal communication. That said, I take the utmost caution with my email and phone. I need you to know that e-communication is not secure and that we communicate over email and text at the modern risk of e-info-theft.

_____ _____

Date Signature of Client (digital signatures apply)

I have received/been offered a copy of the Notice of Privacy Practices.

Date/initials: _____

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