Nurturing Expressions, LLC
Lactation Consulting Agreement

CLIENT INFORMATION

Name of Mother: _____ Today's Date: _____
Name of Child / Children: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Secondary Phone: _____
Emergency Contact Name: _____
Emergency Contact Phone: _____ Emergency Contact's Relationship to Mother: _____

CONSENT FOR CARE

As the patient or patient's legal representative, have been informed of the nature, purpose, and scope of the care to be provider by Nurturing Expressions, LLC ("Nurturing Expressions"), the possible limitations and consequences of that care and the possibility that the care given by Nurturing Expressions may not completely resolve the patient's and her child/children's lactation issues.

I hereby grant permission to Nurturing Expressions, its employees and its agents to perform such examinations, render such advice and recommend implementation of such medical and therapeutic procedures, equipment, and treatment as may professionally be deemed necessary or advisable in the diagnosis and treatment of the patient and her child/children. I also grant permission to Nurturing Expressions to employ such established treatment and therapy as may be deemed medically necessary or advisable in the diagnosis and treatment of the patient and her child/children. I acknowledge and accept that a physical evaluation or consultation if any, may be delivered via electronic medium including video telecommunication which may be recorded or preserved as part of my patient records. I understand that federal and state laws concerning the confidentiality of personal health information apply to services delivered and information acquired via video telecommunication, including patient access and amendments to patient records. I understand that in rare circumstances, security safeguards and protocols could fail causing a breach of patient privacy. I understand that information provided by video telecommunication to the consulting provider may be insufficient to allow for client care decisions to be made, and that delays my care may occur due to failures of the electronic equipment.

I will not hold Nurturing Expressions responsible for the consequences of any inaccurate information given by the patient and I am aware that the practice of medicine is not an exact science. Additionally, I acknowledge that no guarantees or promises have been made to me as to the result of the consultation and care. This authorization shall remain in full force and effect unless the consent is cancelled by written notice filed with Nurturing Expressions.

RELEASE OF INFORMATION

I authorize Nurturing Expressions to release all or part of the patient's and her child/children's health information to any person, entity, or organization (including Medicaid) that may be responsible for payment for the care received from Nurturing Expressions when such information is necessary to determine liability for payment and to obtain payment. I hereby release Nurturing Expressions from all legal responsibility that may arise from disclosure of the patient's and her child/children's records to the above person, entities, and organization. I understand that Nurturing Expressions keeps a record of the health care services provided and that I may request to review the record upon twenty-four (24) hours' written notice. Except as noted above, Nurturing Expressions will not disclose the records to others unless I direct it to do so. I certify that the information given in applying for any Medicaid claim is correct.

PRIVACY POLICY

I have received a paper/electronic copy of Nurturing Expressions' HIPAA Privacy Practices

FINANCIAL AGREEMENT

I agree to be responsible for and pay directly to the order of Nurturing Expressions all charges for services rendered under this Agreement and that Nurturing Expressions may impose reasonable interest, late charges, costs, and reasonable attorneys' fees should by account become delinquent and that any lawsuit for collection of the account may be brought in King County, Washington.

I/We have read this consent and understood its contents and affix my signature. I/We acknowledge receipt of a copy of this form.

_____ _____
Signature of Patient or Person Authorized to Give Consent Date

_____
Relationship to Patient

I have reviewed the above terms of this consent with the patient/patient representative named above and I am satisfied that she/they fully understands the nature and content of this agreement.

_____ _____
Signature of Nurturing Expressions Consultant Date

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