FIRST LATCH & COUNSELING, INC.

caring support from the start

HIPAA Privacy Authorization Form

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

I grant permission to First Latch & Counseling Inc., its officers, directors, owners, principals, agents, volunteers, trainees and staff specifically including, without limitation, Jennifer Leopold, Tova G. Ovits Chaya Deborah Stern, and Stephanie Minnich (collectively "First Latch & Counseling Inc.") to share pertinent information about this consultation along with any and all future personal, phone, text and/or email communications with my/our family physicians and health care providers, the referring person, spouse or partner, my/our community breastfeeding helper and/or my/our insurance companies.

I understand that I have a right to revoke this authorization by providing prior written notice to First Latch & Counseling Inc. at 1827 E. 28th Street, Brooklyn, NY 11229. However, this authorization may not be revoked if First Latch & Counseling Inc. has taken action on this authorization prior to receiving my written notice.

First Latch & Counseling Inc. reserves the right to change the privacy practices that are described in this notice. I may obtain a revised notice of privacy practices by writing or calling the First Latch & Counseling Inc. at 917-750-9708 and requesting a revised copy be sent in the mail. Any complaint about an alleged breach of privacy must be submitted in writing to First Latch & Counseling Inc. at the address provided above.

I understand that I have a right to have a copy of this authorization and further understand that this authorization is voluntary and that I may refuse to sign this authorization.

I, _____on this date of _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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Lactation Consultation Services Agreement

I hereby provide consent to First Latch & Counseling Inc. to render lactation consultation services to me. I consent to First Latch & Counseling Inc. conducting a visual and physical assessment of both myself and my baby during the period of lactation assistance. I understand this will include, without limitation, examination of my baby's mouth and observation of their oral-motor skills.

In connection with the services which I am receiving from First Latch & Counseling Inc., I consent to photographs/ videos of myself and my infant(s) including parts of our bodies (the "Depictions"). It is specifically understood that the Depictions will not identify me or my infant by name nor shall my face be visible. I hereby grant First Latch & Counseling Inc. together with their licensees, assigns and those acting with their permission or upon their authority ("Licensed Parties"), the absolute and unrestricted right and permission to copy, reproduce, publish, televise, exhibit, distribute, license, disseminate, display and otherwise use the Depictions in their discretion. I hereby waive any right to inspect or approve the Depictions and this grant of rights is made without limitation upon time, circumstances, location, market or medium of use whether now known or hereafter devised. Recognizing First Latch & Counseling Inc.'s reliance upon this agreement, I hereby irrevocably release, discharge and agree to indemnify and hold harmless the Licensed Parties from and against all actions, damages, costs, liabilities, claims, losses and expenses of every type and description (including attorney fees and expenses) to which any of the Licensed Parties may be subject as a result of, or in any way related to, any use of the Depictions by any of the Licensed Parties, including without limitation, any claim for violation, infringement or invasion of any copyright, privacy or publicity right, defamation or any other right whatsoever that I now have or may ever have resulting from or relating to any such use of the Depictions.

First Latch & Counseling Inc. is an out-of-network provider. I/We are responsible for all fees which are due at the time of service. Cash and checks, are acceptable forms of payment and any other mutually acceptable forms. Upon your request, an invoice with procedure codes and diagnosis codes can be filled out for you to submit to your insurance company. First Latch & Counseling Inc. is not however responsible for your insurance company's failure to reimburse.

I/We understand that all medical care is to be provided by my/our own physician(s). First Latch & Counseling Inc. is not responsible for the conduct of any providers to whom you may be referred. I hereby irrevocably release, discharge and agree to indemnify and hold harmless First Latch & Counseling Inc. from and against any and all actions, damages, costs, liabilities, claims, for any losses, injuries, property damage, equipment failures, death, and expenses of every type and description (including attorney fees and expenses) to which they may be subject as a result of, or in any way related to, resulting from, or relating to, their provision of services during my consultation as well any subsequent services rendered incident thereto. Any potential liability by First Latch & Counseling Inc.

shall be capped at a maximum amount which is the equivalent of the fees paid to First Latch & Counseling Inc. for services rendered.

This agreement shall be construed in accordance with the Laws of the State of New York governing contracts executed and to be wholly performed therein, and shall be binding upon and inure to the benefit of the parties and their respective heirs, executors, administrators, successors and assigns. It is agreed that the courts of the State of New York within the County of Kings shall have sole and exclusive jurisdiction and the venue in any lawsuit commenced by either party concerning the subject matter of this agreement and the parties specifically consent to personal jurisdiction thereof. If any action at law or in equity is brought to enforce or interpret the provisions of this agreement, the prevailing party in such action shall be entitled to reimbursement for reasonable attorneys' fees and costs.

This agreement sets forth the entire understanding and Agreement between the Parties hereto with respect to the subject matter hereof, supersedes all prior agreements understandings, and arrangements, and no change, modification, amendment, waiver, termination or discharge of this Agreement shall be binding unless confirmed by a written instrument signed by the parties.

Print Full Name_____

Signature_____

This agreement is effective as of: Date _____

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INTAKE FORM

Date _____

Parent's Name _____ Date of Birth _____

Address _____

City/State/Zip Code _____

Home Phone _____ Cell Phone _____

Email _____

Occupation _____

Will you be returning to work/school? When? _____

YOUR PARTNERS INFORMATION

Spouse/Partner's Name _____ Cell Phone _____

Allergies? ☐ No ☐Yes Please explain: _____

Smoke Cigarettes? ☐ No ☐ Yes

Family history of orthodontal interventions, and/or speech or feeding issues? ☐ No ☐ Yes

HOW CAN WE HELP YOU?

Reasons for your appointment?

☐ Baby won't latch

☐ Baby won't stay latched

☐ Painful at initial latch to breast

☐ Painful throughout feeding

☐ Baby's weight gain isn't as expected

☐ Pediatrician recommended lactation support

☐ Baby isn't acting as expected

☐ Bonding Difficulty

☐ Other. Please be specific. _____

_____

_____

_____

Jennifer Leopold, IBCLC, LMSW Tova Ovits, IBCLC Chaya D. Stern, IBCLC, RN Stephanie Minnich, CBC

What solutions or interventions have you used to assist you with your problems? _____
_____
_____
_____

MATERNAL BIOPSYCHOSOCIAL HISTORY

Allergies? ☐ No ☐Yes Please explain: _____
_____
_____
_____

Smoke Cigarettes? ☐ No ☐ Yes # of years _____ # per day _____

Alcohol? ☐ No ☐ Yes Frequency: _____

Marijuana/Narcotics? ☐ No ☐ Yes Frequency/Type: _____

Age of first menstrual period: _____

Do you use(d) hormonal birth control? ☐ No ☐ Yes

If yes, how old were you when you started hormonal birth control? _____

If you use(d) hormonal birth control, which did you use?

☐ IUD ☐ the Pill ☐ the mini Pill ☐ Injection ☐ Implant ☐ Other_____

Are you currently taking a hormonal birth control? ☐ No ☐ Yes

# of Living Children _____ # of Pregnancies _____ # of Births _____

If you have more children, please describe their breastfeeding history. _____

_____

_____

Did you notice breast changes during pregnancy? ☐ No ☐ Yes ☐ A little

BREAST HISTORY

☐ Augmentation: Date of surgery ____/____/_____ ☐ Reduction: Date of surgery ____/____/_____

☐ Accident/Injuries/Burns _____

MEDICAL HISTORY ("X" only if applicable)

☐ polycystic ovarian syndrome (PCOS)

☐ infertility

☐ thyroid problem

☐ diabetes (including gestational)

☐ anemia

☐ hormonal disorder

☐ irregular periods

☐ high blood pressure

☐ low blood pressure

☐ pre-eclampsia

☐ severe swelling in pregnancy/after birth

☐ depression

☐ anxiety

☐ eating disorders

☐ herpes virus

☐ HIV/AIDS

☐ None

☐ other: _____

_____

Current prescriptions or over-the-counter medications: _____

_____

_____

BIRTH INFORMATION

☐ Birthing Center ☐ Home (☐Planned/☐Unplanned) ☐ Hospital ☐ Other (car/ambulance)

Doula at birth ☐ No ☐ Yes

Was your conception medically assisted? ☐ No ☐ Yes (Please explain) _____

_____

Describe your pregnancy: ☐ Typical ☐ Complicated (Describe please) _____

_____

TYPE OF DELIVERY

Induction ☐ No ☐ Yes ☐ Vaginal ☐ Vacuum Assisted ☐Forceps ☐ Episiotomy

hours in labor if induced _____ ☐ C-Section ☐Planned or ☐ Emergency

MEDICATION USED DURING LABOR/DELIVERY

☐ Epidural ☐ Spinal ☐ IV Pitocin during delivery ☐ IV Pitocin after birth ☐IV Fluids

☐IV Medication (ie: Group B Strep) ☐IV Antibiotics ☐ IV Fluids within 2 hours of the birth

☐Other pain medications _____

DELIVERY COMPLICATIONS

☐ Failure to progress ☐ Fetal distress ☐ Maternal distress ☐ Hemorrhage following birth

☐ NICU admission ☐ Other _____

BABY HISTORY

Name _____ Date of Birth _____

Delivered at gestational age _____weeks _____days Birth Weight _____

Lowest Weight _____ on _____ /_____ / _____

Current Weight _____ as of _____ /_____ / _____

of wet diapers in 24 hours _____ # of **dirty diapers** in 24 hours _____

Jaundice ☐ No ☐ Yes (highest Bilirubin _____)

Describe any additional important information about your baby: _____

_____

After birth were you and your baby separated? ☐ No ☐ Yes Please explain: _____

_____

Was baby rooming in at the hospital? ☐ No ☐ Yes

Do you have support at home? ☐ Yes, my partner, other family member or friend

☐ Postpartum doula at home ☐ Baby nurse at home during day/night ☐ No

Are you using a pump? ☐ No ☐ Yes

Are you using pacifiers? ☐ No ☐ Yes

Are you using bottles? ☐ No ☐ Yes

HEALTH CARE PROVIDER INFORMATION

Midwife/OBGYN _____ Phone _____

Address _____

City/State/Zip Code _____

Pediatrician's Name _____ Phone _____

Address _____

City/State/Zip Code _____

INSURANCE INFORMATION

Although we are out-of-network providers, however your insurance company may reimburse you for our fee. Which insurance plan do you have? (ie. Cigna, Aetna, Blue Cross, United Healthcare, Medicaid plan)

Insurance Provider: _____ ID # of Mother _____

ID # of Baby (if baby is 28 days or older) _____

OUR SUPPORT CONTINUES

Are you interested in attending support group for new mothers? ☐No ☐ Yes

Are you interested in individual or family counseling sessions? ☐ No ☐ Yes

How did you find out about The First Latch & Counseling, Inc.? _____