Dear New Patient,

Welcome to Whole Health Naturopathy for your Initial Lactation Consultation with Carrie DiStefano, IBCLC. This letter outlines the benefits of lactation services at Whole Health Naturopathy, what to bring to the appointment and, on the second page, how to inquire about your insurance benefits specific to this visit.

Benefits of scheduling at Whole Health Naturopathy:

- One-to-one, personal and in-depth interaction with lactation expert
- Payment for the visit at time of service is not required and insurance is billed on your behalf
- All visits are overseen by a physician. The physician is available to step in if additional evaluation and management are required (i.e. prescription)

Please bring the following to each lactation visit:

- Mom and baby!
    - Please do not breastfeed or pump immediately before visit. Last feed is recommended to be no more than an hour before appointment time. We want to observe a feeding under normal conditions and need to assess milk supply and milk intake. Example: if appointment is at 1:30pm last feeding should be no later than 12:30. We know this is not always easy, but do your best!
- Nipple shields if you use them. Please bring all sizes you have as sometimes mothers may be using an incorrect size.
- A clean breast pump and all pump parts (if pumping is a part of your routine) so that we can check its fit
- Expressed breast milk and/or formula, and preferred device for feeding baby, if you are using either of these to supplement
- A (recent) weight history for your baby and medications/supplements that you or baby may be taking
- We welcome partners, grandparents, siblings, or helpers – as long as they are all healthy!

Please see the next page for instructions on checking insurance benefits.

Insurance coverage:

- All visits are billed under the overseeing naturopathic physician's license, and visits are billed separately for mom and baby
- Lactation visits are billed under Nutrition or Counseling codes. **Please call your insurance before your visit to verify if you have these benefits:**
    1. Ask if you have coverage to see naturopathic doctor
    2. For mom's portion of the visit, ask if you have Preventative Counseling benefits, CPT code 99404
    3. For infant's portion of the visit, ask if he or she has Nutrition benefits, CPT code 97802 (initial) and 97803 (follow up)
    4. Inquire if your plan has benefit limits for counseling and nutrition
- Insurance has not yet developed lactation codes that apply to the outpatient clinical setting (outside of a hospital or home visit setting), so inquiring about "Lactation Benefits" may be misleading
- Insurance coverage for your visits may be applied to your deductible and there may be an applicable co-pay or co-insurance.
- You will be financially responsible for the amount determined by your insurance coverage. Whole Health Naturopathy mails out patient invoices monthly.

Thank you for taking the time to read through this and better understand insurance and lactation benefits.

Please contact us if any further clarification is needed. We look forward to meeting you and helping you meet your breastfeeding goals!

Sincerely,

Whole Health Naturopathy

Whole Health Naturopathy

Marnie Frisch ND & Savahn Rosinbum ND
1212 4th Ave E / Olympia, WA 98506
360-943-9519 F: 360-943-9534

Parent

REGISTRATION FORM

Today's date	PCP

PATIENT INFORMATION

Patient's Legal Last Name	Legal First	Middle initial	Preferred Name	Age	Birth Date
					/ /

Former name, if any	Marital Status	Gender & Preferred Pronouns	Legal Sex
			❑ M ❑ F

Street address	E-mail Address	Home phone
		( )

City	State	ZIP Code	Cell phone
			( )

Occupation	Employer	Work phone
		( )

At which of these phone numbers can we leave a detailed message?
Chose clinic because/was referred to clinic by
Other family members seen here

INSURANCE INFORMATION

Please give your insurance card to the receptionist. It is your responsibility to contact your insurance company to verify coverage for Naturopathic physicians and services. Your policy may not cover claims made by this office, which will leave you responsible for the charges.

Person responsible for bill	Address (if different)	Home phone
		( )

Is this person a patient here? ❑ Yes ❑ No	Date of Birth / /	

Occupation	Employer	Employer address	Employer phone
			( )

Is this patient covered by insurance? ❑ Yes ❑ No	Referral needed from PCP?

Name of primary insurance	Group number	ID number	Co-payment amount

Subscriber's name	Subscriber's Address	Birth date

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable)	Subscriber's name	Group #	Policy #

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient	Home phone	Work phone
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Whole Health Naturopathy or insurance company to release any information required to process my claims.

Whole Health Naturopathy

Marnie Frisch ND & Savahn Rosinbum ND
1212 4th Ave E / Olympia, WA 98506
T: 360-943-9519 F: 360-943-9534

Baby

REGISTRATION FORM

Today's date	PCP

PATIENT INFORMATION

Patient's Legal Last Name	Legal First	Middle initial	Preferred Name	Age	Birth Date / /

Former name, if any	Marital Status	Gender & Preferred Pronouns	Legal Sex ❑ M ❑ F

Street address	E-mail Address	Home phone ( )

City	State	ZIP Code	Cell phone ( )

Occupation	Employer	Work phone ( )

At which of these phone numbers can we leave a detailed message?

Chose clinic because/was referred to clinic by

Other family members seen here

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(Please give your insurance card to the receptionist.) It is your responsibility to contact your insurance company to verify coverage for Naturopathic physicians and services. Your policy may not cover claims made by this office, which will leave you responsible for the charges.

Person responsible for bill	Address (if different)	Home phone ( )

Is this person a patient here? ❑ Yes ❑ No	Date of Birth / /	Occupation

Employer	Employer address	Employer phone ( )

Is this patient covered by insurance? ❑ Yes ❑ No		Referral needed from PCP?	
Name of primary insurance	Group number	ID number	Co-payment amount

Subscriber's name	Subscriber's Address	Subscriber's Date of Birth / /

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable)	Subscriber's name	Group #	Policy #

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient	Home phone ( )	Work phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Whole Health Naturopathy or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

LACTATION CONSULTATION

INTAKE AND CONSENT FORM

MOTHER

Your Name _____ Your Birth Date ___/___/___ Your Age _____ Your Profession _____

Street Address _____ City _____ State _____ Zip _____

Partner's Name _____ Partner's Profession _____ Best phone to reach you: ❑ Home/Landline ❑ Cell

Phone (home/landline) _____ Phone (cell) Do you text? ❑ Yes ❑ No _____ 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 ❑ Faxed To: _____

Referred by: ❑ Friend/Family:_____ ❑ Hospital:_____ ❑ Doctor: _____

Website: ❑ _____ ❑ Internet search ❑ Other referral source: _____

BABY

Baby's Full Name _____ Sex: ❑ M ❑ F Due Date ___/___/___ Birth Date ___/___/___ Weeks Gestation at Birth _____

Place of Birth _____ City/State of Birth _____

INSURANCE

Insurance Company _____ Primary Insured's Name _____

Primary Insured's Employer _____ Date of Birth ___/___/___ ❑ Self ❑ Spouse ❑ Other Relationship to Mother

Member Number:_____ Group Number: _____

HEALTH CARE PROVIDERS

OBSTETRICIAN / MIDWIFE	PEDIATRICIAN
Name _____ Send report? ❑ No ❑ Yes (provide following info):	Name _____
City and State _____	City and State _____
Phone _____	Phone _____ Fax _____

I understand that:

- All medical care is to be provided by my own physician(s) and that any change from his/her/their recommendations should be discussed with him/her/them.
- A lactation consultation by the IBCLC may include a visual and manual assessment of the mother's breasts, the baby's mouth and suck, observation of the mother and baby breastfeeding, analysis of information relating to the breastfeeding situation, demonstration of techniques for improving breastfeeding, use of breastfeeding equipment, and recommendation of a care plan to resolve breastfeeding issues, which may be adjusted during the course of treatment.
- A student intern may accompany the IBCLC and participate in the consultation for training purposes.
- I am responsible for informing the lactation consultant(s) of any relevant information or changes that affect my breastfeeding situation.
- *It is my responsibility to call the lactation consultant(s) with progress reports, questions, or concerns.*
- This practice will submit a claim for direct payment of insurance benefits with participating insurance company and bill me for any remaining co-pay or fees. For those who are not insured or who are insured with a company with which we do not participate, payment for services and supplies are my sole responsibility and required at the time of service; a receipt will be provided for insurance reimbursement.

I grant consent for:

- Information about this consultation to be mailed, faxed, or emailed to my attending physician/health care providers.
- The release of any medical information necessary to process any insurance claim(s) and payment of any insurance benefits directly to this practice.
- Information from this consultation to be used for teaching purposes, with the understanding that no names or identifying features will be used.
- Treatment according to the scope of practice outlined above.

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

_____ _____

Client Signature **Date**

_____ **INITIALS** 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.

INTAKE HISTORY

PAGE ONE

Mother's Name _____

Consultation Date _____

Problem: ❑ nipple pain ❑ latch ❑ breast refusal ❑ undersupply ❑ oversupply ❑ slow weight gain ❑ multiples ❑ other_____

Others consulted about this breastfeeding issue: ❑ LC ❑ doctor ❑ nurse ❑ LLL ❑ friend ❑ family ❑ doula ❑ other _____

Ultimate breastfeeding goal: ❑ breastfeed exclusively ❑ pump exclusively ❑ bf and pump ❑ bf and supplement ❑ unsure ❑ whatever happens

YOUR HEALTH HISTORY

Any history of: ❑ thyroid ❑ ovarian cyst ❑ Polycystic Ovarian Syndrome (PCOS) ❑ diabetes (type ❑ I ❑ II) ❑ other: _____

_____

Medications currently taking (including herbs and vitamins): _____

Breast or chest surgery or injury: ❑ none ❑ reduction ❑ mastopexy ❑ augmentation ❑ biopsy ❑ injury ❑ other **Date:**_____

Conceive easily: ❑yes ❑ no (how long: _____) ❑ IVF ❑ IUI (donated: ❑ sperm ❑ egg ❑ neither)

Abortion(s): ❑ no ❑ yes (#_____ year(s) _____) **Miscarriage(s)**: ❑ no ❑ yes (#_____year(s) _____)

Miscarriage(s) reason(s): ❑ unknown ❑ _____

Number of other pregnancies: _____ **Number of other children living:** _____

BREASTFEEDING HISTORY

Number of other children breastfed: _____ **How long other child(ren) breastfed: #1:** ____ ❑ wks ❑ mos ❑ yrs

#2: ____ ❑ wks ❑ mos ❑ yrs | **#3:** ____ ❑ wks ❑ mos ❑ yrs | **#4:** ____ ❑ wks ❑ mos ❑ yrs | **#5:** ____ ❑ wks ❑ mos ❑ yrs

How did breastfeeding go with the older child(ren): ❑ easy ❑ difficult (describe): _____

_____

_____

THIS PREGNANCY

Breast changes: ❑ enlargement ❑ tenderness in first trimester ❑ leaking ❑ areola darkening **Any complications:** ❑ no ❑ yes: _____

_____

Bed Rest: ❑ no ❑ yes (start week: _____ until week_____**)** **Reason:** _____ **Pregnancy length:** _____ wks _____ day(s)

LABOR

How labor began: ❑ spontaneous ❑ induced (how: ❑ pitocin ❑ cervical gel ❑ membrane ruptured ❑ other:_____)

Where: ❑ home ❑ birth ctr ❑ hospital ❑ other **Labor:** ___ hrs **Pushing:** ____ min **Delivery:** ❑ vag (❑ VBAC) ❑ vacuum ❑ forceps ❑ C-sect

Medications during labor: ❑ pitocin ❑ epidural (#cm when started: _____) ❑ narcotic (demerol, nubain) ❑ other _____

Antibiotics: ❑ no ❑ yes (reason: ❑ strep B ❑ fever ❑ C-sect ❑ other _____) **Hemorrhage:** ❑ no ❑ yes (med to stop: _____)

LABOR EXPERIENCE: _____

_____

_____

HOSPITAL / POSTPARTUM

1st nursing: ____ min /hrs after birth ❑ easy ❑ difficult **Sides:** ❑ 1 ❑ 2 **When milk came in:** day ____ ❑ not noticed ❑ slight ❑ mod ❑ heavy

1st 24 hours frequency: every_____ hours **2nd 24 hours frequency:** every_____ hours **3rd 24 hours frequency:** every_____ hours

❑ **Circumcision** (Day _____) **Pacifier:** ❑ no ❑ yes (when began: day_____) **Separation:** ❑ none ❑ some ❑ night ❑ mostly nursery ❑ NICU

Baby complications: ❑ jaundice ❑ hypoglycemia ❑ other _____ **How treated:** _____

INPATIENT BREASTFEEDING EXPERIENCE: _____

_____

_____

_____

_____

INTAKE HISTORY

PAGE TWO

AT HOME

FEEDINGS: **How often**: ____ min/hrs **LATCHING**: ❑ easy ❑difficult ❑ impossible **Who ends:** ❑ me ❑ baby **Avg length:** ____ min

Nipple pain: ❑ none ❑ some ❑ moderate ❑ severe **Which nipple(s)**: ❑ L ❑ R **When began**: _____ ❑ days ❑ weeks ❑ months

SUPPLEMENTING: ❑ no ❑ yes **When began**: ____ days **How:** ❑ bottle ❑ cup ❑ syringe ❑ dropper ❑ spoon ❑ finger-feeder ❑ tube

When: ❑ before nursing ❑ after **How often:** ❑ every feed ❑ _____ x/day **How much:** ____oz/cc /feeding **What:** ❑ formula ❑ pumped milk

PUMPING: ❑ no ❑ yes **When began**: ____ days **How often:** _____ x/day **Avg amt:** _____ **Flange size** (imprinted on side): _____

Pump condition: ❑ new ❑ used (how long: _____ mths/yrs) **Pump Type**: ❑ rental ❑ owned (brand: _____)

POST-DISCHARGE BREASTFEEDING EXPERIENCE:_____

_____

_____

_____

_____

_____

_____

_____

Vaginal bleeding now: ❑ light ❑ moderate ❑ heavy ❑ over **Color:** ❑ bright red ❑ dark red ❑ brown

WHERE BABY SLEEPS: ❑ in our room ❑ in her/his room ❑ other:_____ **What baby sleeps in**: ❑ our bed ❑ co-sleeper ❑ crib/bassinet

NUMBERS

BABY'S WEIGHT HISTORY

DATE	WHERE WEIGHED	WEIGHT
BIRTH		

DIAPER OUTPUT HISTORY

DAY	Last 24 Hours	Last 25-48 Hours	Last 49-72 Hours	Last 73-96 Hours	Last 97-120 Hours
No. of Stools					
Stool Qty	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful
Stool Color	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow

Attend breastfeeding mothers' group: ❑ no ❑ yes (Where: _____)

Ideally, want to breastfeed: _____ ❑ months ❑ years ❑ until baby weans self **Returning to work (outside home):** ❑ no ❑ yes (At _____ ❑ wks ❑ mos)

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Carrie DiStefano IBCLC, Dr. Marnie Frisch, and Dr. Savahn Rosinbum of Whole Health Naturopathy to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Whole Health Naturopathy describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Carrie DiStefano IBCLC, Dr. Frisch & Dr. Rosinbum reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Whole Health Naturopathy at the above address.

With this consent, Carrie Distefano IBCLC, Dr. Frisch & Dr. Rosinbum may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Carrie DiStefano IBCLC, Dr. Frisch & Dr. Rosinbum may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Carrie DiStefano IBCLC, Dr. Frisch & Dr. Rosinbum may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Marnie Frisch restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Carrie Distefano IBCLC, Dr. Frisch & Dr. Rosinbum to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Carrie DiStefano IBCLC, Dr. Frisch & Dr. Rosinbum may decline to provide treatment to me.

_____	_____	_____
Print Name of Patient or Legal guardian	Signature of Patient or Legal Guardian	Date

Notice of Privacy Practices Acknowledgement

This form is used to ensure that you have had the opportunity to read and review the health care practitioner's Notice of Privacy Practices which are available on the website www.olympianaturopath.com and in the Whole Health Naturopathy office.

The Notice of Privacy Practices describes how medical information about you may be used and disclosed, how you can get access to this information and who to contact if you have questions, concerns, or complaints.

Health care practitioners have a responsibility to protect the privacy of your information. You are entitled to receive their Notice of Privacy Practices that describes the health information privacy practices that have been put in place to protect your privacy.

If you have any questions, contact the privacy officer identified in the Notice of Privacy Practices.

Any significant change in these privacy practices will be posted. You may request a copy of the Notice of Privacy Practices at any time by contacting your practitioner or the privacy officer.

You may request a copy of this signed acknowledgement.

By signing below, I agree that I have received the Notice of Privacy Practices.

_____

_____

(Signature of patient or legally authorized person)

Date

_____

_____

(Printed Name if not the patient)

(Relationship to Patient)

For Office Use Only *(ver. 16.1)* Date Received: _____
File Reference #: _____ Action: _____
Person acting: _____ ¨Response Date : _____ ¨Filed Without Response