Consent for Care for Telelactation

I understand that during a virtual consult for lactation support, Your Lactation Nurse Inc., Brandee Gutowsky, IBCLC may examine me and my breasts visually, may examine me and my baby or babies visually, may observe me and my baby while feeding, may make clinical observations, may provide information on techniques and breastfeeding, pumping, and feeding equipment, and will make recommendations towards helping me reach my goals. Your Lactation Nurse Inc. will guide me in positioning my camera to be able to see me and my baby, and will direct me in assessments of my breasts and/or my baby in the furtherance of my care.

I understand no outcome can be guaranteed. I acknowledge that there may be some limitations with virtual care (telehealth).

I will provide Your Lactation Nurse Inc. with the names and contact information for other relevant healthcare providers for me and my baby, and Your Lactation Nurse Inc. may communicate with them. It is my responsibility to provide accurate information and to keep it updated.

I understand that it is my choice to have someone else present during the visit, and that anyone who sits in on the visit will have access to my healthcare information and my confidentiality may not be guaranteed. I have provided written notice to Your Lactation Nurse Inc. of any person(s) I wish to have present during the visit. I understand that if I include any third party on an email or text with Your Lactation Nurse Inc., I am granting permission for Your Lactation Nurse Inc. to communicate my health information and that of my baby or babies with that third party. Your Lactation Nurse Inc. will not initiate inclusion of any third party on an email or text. I acknowledge that Your Lactation Nurse Inc. is not responsible for any breach of

confidentiality made by any person present I invite to be present during a visit, or added by me as a third party to text or email.

I have read and reviewed Your Lactation Nurse Inc.'s payment policies and understand that I am responsible for all charges associated with this visit. Your Lactation Nurse Inc. is providing care to me and to my baby or babies; together we are all the client of Your Lactation Nurse Inc. Your Lactation Nurse Inc. may communicate with my insurance company in reference to the services provided to me and my baby or babies. Your Lactation Nurse Inc. may communicate with my credit card company or bank for any payment related matters. It is my responsibility to provide accurate and current payment and insurance information.

If you cannot access our HIPAA secure messaging platform, we may use the non-HIPAA compliant platform of your choice, as long as it is private.

I agree to meet with Your Lactation Nurse Inc. through "Google Meet".

For Photo and Video, please see "Consent for Photography/Videography."

Name / DOB: _____

Child's name: _____

Signature: _____

Date: _____