Village Pointe Pediatrics, P.C.

Lactation Consultation Registration

Consent to Treat / Billing Authorization/ Release of Protected Health Information

PATIENT NAME: Last: _____First_____M.I. _____ DOB: _____/_____/_____

INFANT NAME: Last: _____ First _____M.I. _____ DOB: _____/ _____/_____

Primary Insurance If we have the insurance information on file for your infant, may we retrieve this information for your file? ___YES
If your insurance information is different from your infant, please fill out below and present your insurance card to our staff.

Insurance _____Last Name: _____First :_____DOB:___/____/____

SECTION A – Description of Lactation Services

I understand the following:

Initial: _____ The lactation consultant is an allied health care provider. Under most insurance plans lactation consultations are a covered benefit. Please contact your insurance carrier for your benefits related to this service and the billing code 99404.

Initial: _____ Village Pointe Pediatrics will submit a claim for services to the insurance information you provide to our office. Payment for the claim will come directly to our office and we will bill you for any remaining balance.

Initial: _____ The lactation consultant will be responsible for evaluating and recommending treatment to resolve or improve breast feeding issues. The visit includes a detailed history, observation of the mother/infant breast feeding, visual and manual assessment of mother/infant anatomy, demonstration of techniques for improving breastfeeding and use of breastfeeding equipment.

SECTION B - Description of Authorization to Release PHI – This section authorizes the release of your PHI to another person or entity.

Initial: _____ I, the above named patient, authorize Village Pointe Pediatric, P.C. (VPP) to release my Protected Health Information (PHI). PHI is information about myself that may identify and relate to my past, present or future physical or mental health or condition and related health services.

Initial: _____ I hereby authorize VPP to release my PHI to my baby's pediatrician, primary health care provider or referring physicians.

Initial: _____ I hereby authorize VPP to release PHI necessary to process any insurance claim(s) and payment of any insurance benefits directly to VPP.

SECTION C - Terms and Conditions of Authorization

I understand that I do not have to sign this authorization to obtain health care benefits. I may revoke this authorization in writing at any time.

SECTION D - Financial Responsibility: I am aware that I am responsible for any outstanding balance whether or not paid by my insurance. I authorize payment of insurance benefits directly to VPP. I understand that it is my responsibility to know my insurance benefits and coverage.

HIPAA: I acknowledge receipt of Notice of Privacy Practices as set forth by the Health Information Portability and Accountability Act (HIPAA) at this visit and at any future visits.

Consent to Treat: I, the above patient, give VPP consent to administer care/treatment by the health care providers employed by Village Pointe Pediatric, P.C.

Signature:_____ Date: _____/_____/_____