Village Pointe Pediatrics, P.C.
18018 Burke Street
Elkhorn, NE 68022
Phone (402) 573-7337
Fax (402) 614-2314

Dundee Pediatrics
5018 Underwood Ave., Ste 200
Omaha, NE 68132
Phone (402) 991-5678
Fax (402) 991-5358

village pointe | dundee pediatrics

LACTATION CONSULTATION REGISTRATION, CONSENT TO TREAT & FINANCIAL AGREEMENT

PATIENT / MOTHER INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Primary Phone #: _____ Primary Insurance: _____

INFANT INFORMATION (for clinical reference only)

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Primary Insurance: _____

CONSENT TO LACTATION CARE

I understand that I am receiving lactation care and support from Village Pointe Pediatrics, P.C. and/or Dundee Pediatrics, and their physicians, lactation consultants, nurses, and staff.

This care may include help with breastfeeding or pumping concerns, feeding assessments, observation of feeding, physical assessment related to lactation, and education or recommendations to support feeding my baby.

I understand that my baby may be present during visits and may be observed or included as part of my care.

FINANCIAL RESPONSIBILITY AND INSURANCE

I understand that I am responsible for charges related to lactation services provided to me, whether or not my insurance pays for them.

I understand that insurance coverage for lactation services varies and may not be fully covered. It is my responsibility to understand my benefits and any requirements from my insurance plan.

I authorize insurance payments to be made directly to Village Pointe Pediatrics, P.C. and/or Dundee Pediatrics.

Any remaining balance not covered by insurance will be my responsibility and is due according to office policy. The full Financial Policy is available upon request.

HIPAA PRIVACY ACKNOWLEDGMENT

I acknowledge that a copy of the Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act (HIPAA) is available upon request.

I authorize Village Pointe Pediatrics, P.C. and/or Dundee Pediatrics to use and disclose my medical information as necessary for treatment, care coordination, consulting services, and insurance billing.

_____
Signature of Patient

_____ _____
Printed Name Date

STAFF ONLY	