HIPAA Notice of Privacy

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law designed to protect your privacy whenever your health care providers have to discuss your case, or send information about you to different offices. We have to keep a file to record our consult - but we promise that the private, protected health information in it will be kept confidential.

Health care providers can freely share all the details of your personal health information for purposes of "treatment, payment and health care operations." That means we can talk to you about your situation, and discuss it with your other health care providers. If you are referred to other specialists, we can send the information on to them. We can also share information with your health insurance company if they need it.

The law also requires us to share your information under other, very precise situations: for example, if a subpoena has been served on this office, to turn over medical records or a federal agency is investigating a complaint that we have not been protecting your privacy.

Any other time we share your personal health information, it has to be with your specific authorization: you have to okay it, in writing, first. When you do give us permission to turn over information about you, we can give out only the minimum amount of information needed to get the job done.

Under HIPAA, we can call or write you to remind you to come back for an appointment, or to tell you how you can get a product or service that might interest you and your family.

You have four rights under HIPAA:

1. Access (you can ask to see all the protected health information (PHI) we have about you);
2. Amendment (you can ask to have changes made to files to amend inaccurate PHI);
3. Disclosure Accounting (you can ask to whom we have given your PHI) and
4. Restriction Request (you can put limits on the use and sharing of your PHI).

Our duty under to HIPAA is to give you this notice, so you understand we have promised to keep your private health information confidential. If we change this notice in the future, we'll give you a new copy.

Nicole Letizia, CLC is the owner and Privacy Officer of Boobie Babies. I can answer your questions or concerns about how we protect your privacy.

You can complain if you think your privacy hasn't been protected and we have a duty to attempt to address the situation. We can't penalize you for making a complaint. If we don't address your complaint adequately, you can go to the Office for Civil Rights (OCR) of the federal Health and Human Services Dept., to ask that a formal investigation be made. You can get more information about filing a complaint by calling (toll free) 1-800-368-1019.

Privacy in Communication

You may initiate communication in the following ways: phone call, text, e-mail, or Facebook message. Phone calls or in person will always be the most secure. I welcome communication from you in any form. I will always do my best to maintain your privacy; by choosing the communication method you are accepting the risk of loss of privacy inherent in the form chosen.

Please retain this copy for your records.

NicoleLetizia@boobie-babies.com | 914-996-7719 | www.boobie-babies.com

Acknowledgement of Notice of Privacy Practices

My signature below acknowledges that I have received Boobie Babies's HIPAA Notice of Privacy and that I have read and understand the information contained in this document. I have been given a chance to ask questions and they have been answered to my satisfaction. I give Boobie Babies and Nicole Letizia, CLC permission to share my personal information and information about my case with my healthcare providers, my child's healthcare providers, and my insurance company.

_____

Signature

_____

Printed Name Date

Consent to share information about your case for other purposes

Please initial next to each line where the proposed documenting or sharing of your information is acceptable to you. You can choose not to give permission for any of this additional use of your health information. You can revoke the permissions at any time. You must notify Boobie Babies in writing to revoke permissions. Please note that the consent to sharing of information to health-care providers and insurance companies is necessary in order to provide care. The permissions below are in addition to the required permissions.

Consent to share my information with others:

_____ Nicole Letizia, CLC may share information about my case with other health care professionals, which may include but is not limited to: medical doctors, chiropractors, body work therapists, lactation consultants, and lay counselors for the specific purpose of **gathering information to better treat my case**. This includes, but is not limited to: verbal communication, email communication, professional listservs, and social media. You will not be identified in any of these communications unless a referral is being made.

_____ Nicole Letizia, CLC may share information about my case with other health care providers, lactation consultants, and lay counselors in order **to help educate or provide potentially valuable information** that may help treat others. This includes, but is not limited to: verbal communication, email communication, professional listservs, and social media. You will not be identified in any of these communications.

_____ Nicole Letizia, CLC may publish information about my case in medical, scientific, or lay publications. You will also receive a separate consent if your case is proposed to be published. This will not be done without your express permission for the specific intended publication, but this serves as the initial acknowledgement that any information gathered or data collected about your case may be retrospectively used in this manner.

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_____ Nicole Letizia, CLC may communicate about my case with the following individuals. Examples may include a spouse, parent, sibling or friend.

1.	_____	_____	_____
	Name	Contact info	Relationship
2.	_____	_____	_____
	Name	Contact info	Relationship
3.	_____	_____	_____
	Name	Contact info	Relationship

Consent to photograph:

_____ Nicole Letizia, CLC may take my picture or my baby's picture in order **to document or treat my case**. Any photos taken for this purpose may be shared with your or your baby's health care providers. You will always be asked for permission before any photo is taken.

_____ Nicole Letizia, CLC may take my picture or my baby's picture in order **to document my condition for the purposes of educating others** and/or to add to the body of scientific knowledge. You will not be identified in these pictures. They may be shared with other clients or in public arenas, including website blogging, publication, for scientific or educational purposes. You will always be asked for permission before any photo is taken.

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Consent To Treat

Please read and check each box before signing.

☐ I understand that all medical care is to be provided by my own physicians and that any change from a physician's recommendations should be discussed with the physician.

☐ I understand that breastfeeding counseling by Nicole Letizia, CLC may include a visual and manual assessment of the breastfeeding parent'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 treatment plan to resolve breastfeeding issues, which may be adjusted during the course of treatment.

☐ I hereby give consent for treatment according to the scope of practice outlined above. I understand that I am responsible for informing Nicole of any relevant information or changes that affect my breastfeeding situation.

☐ I understand that it is my responsibility to contact Nicole with progress reports, questions, or concerns.

☐ I understand that payment for breastfeeding counseling services and any necessary breastfeeding equipment are my sole responsibility and expected at the time of service. A receipt will be provided for insurance reimbursement if qualified.

☐ I understand that the results are not guaranteed. I do not expect Nicole Letizia, CLC to be able to treat all complications effectively and understand that she will be able to explain all treatments and recommendations as well as the desired effect of said treatment.

☐ With this knowledge, I voluntarily consent to working with Boobie Babies and Nicole Letizia, CLC. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

_____

Signature

_____

Printed Name Date

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Intake and Patient History

General and Contact Information

Baby's Last Name | First Name | Sex | Age | Date of Birth | Gestational age at delivery

Parent 1: Last Name | First Name | Age | Date of Birth | Occupation

Parent 2: Last Name | First Name | Age | Date of Birth | Occupation

Home Address | City | State | ZIP

Parent 1: preferred phone number | Type (work/cell/ home) | E-Mail address

Parent 2: preferred phone number | Type (work/cell/ home) | E-Mail address

Pediatrician Name | Practice Name | Address

Phone Number | City | State | ZIP

OB/Midwife Name | Practice Name | Address

Phone Number | City | State | ZIP

What are your breastfeeding goals with this child?_____

_____

Describe your current concern/problem_____

_____

_____

_____

_____

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Breastfeeding Parent's Health History

Do you have a history of any of the following?

Breast Surgeries/Injuries Fertility Treatments Diabetes Thyroid issues
PCOS/ovarian cysts

If yes, can you give me a little bit of information about the situation? _____
_____
_____
_____

Medications currently taking (including herbs and vitamins)_____
_____

Number of pregnancies:_____ Number of living children/ages: _____
Do any of your other children have significant or chronic diagnoses?_____
_____
Did you breastfeed your other children? For how long? Any challenges?_____
_____
_____

Baby's Health History

Where was baby born: Hospital Birth Center Home Other _____
Delivery: Vaginal VBAC Vacuum Forceps C-section
Labor began: Spontaneously Induction (type) _____
Length of labor:_____ Hemorrhage? Meds? _____
Medication during labor and delivery (pain meds, antibiotics, etc): _____
Any complications/procedures such as jaundice, hypoglycemia, circumcision, NICU stay, etc? Did these cause a separation between you and your baby?_____
_____
_____

Baby's Weight History

Date	Weight	Where weighed

Is there anything else about you or your baby you'd like me to know? _____
_____
_____

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