Janai Meyer, RD, LD, IBCLC

130 Carlanna Lakes RD Lower

Ketchikan, AK 99901

INFORMED CONSENT FOR TREATMENT

Patient Name _____ Date of Birth _____

I give my consent for treatment from Janai Meyer, RD, LD, IBCLC to myself and/or my child.

I give my consent for Janai Meyer, RD, LD, IBCLC to release any information required in the evaluation and/or management of myself and/or my child to our health care providers, referring physician, and/or our insurance company upon request. I understand that Janai Meyer, RD, LD, IBCLC may contact my physician or primary care provider if she feels it is necessary to consult with them.

I acknowledge that the office Janai Meyer RD LD IBCLC, as a courtesy, will be submitting my services for insurance and/or billing through Alaska Medical Coding Services.

I understand that for all consults the office of Janai Meyer, RD, LD, IBCLC will protect the privacy of my personal health information as required by Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I have read, understand and agree to the above.

_____ _____

Patient or Guardian Signature Date