Agreement for Services

The Mother's Milk Bank at Austin (MMBA) is a non-profit organization providing donor human milk to premature and otherwise fragile infants, as well as other individuals' with a medical need. It is the desire of MMBA to provide donor human milk in a manner protective of the financial solvency and sustainability of the organization.

Applicants must complete this form in full and fax or mail it to us in order to receive any additional shipments of milk from the Mothers' Milk Bank at Austin (MMBA). Please return this form to the address below or fax to (512) 494-0880. If you have questions or concerns please phone us at (512) 494-0800 or toll free at (877) 813-MILK.

Agreement for Services, Parental Responsibility, Informed Consent, Financial Responsibility, and Assignment of Benefits

Recipient_____ **DOB**_____

Parental Responsibility

I understand that I am responsible for providing information on any changes in medical status of my baby (child) including, but not limited to introduction of other foods, changes in milk volume consumed per day, hospitalization, and surgery. I agree to call the milk bank each week with an indication of amount of milk needed to be sent or picked up, and I will obtain updated prescriptions as warranted by either expiration dates or changes in volume. I understand that I am responsible for providing accurate information on insurance coverage and communication with the insurance company, as well as timely notification of changes in insurance. I understand that I must provide a copy of my driver's license and insurance card to MMBA with this completed document.

Informed Consent

I understand that donor human milk is prescribed for my baby (child). I have received verbal and written information from the staff of the Mothers' Milk Bank at Austin (MMBA) on the screening, pasteurization, storage, and handling procedures for donor human milk. I understand that there are no known risks to the use of pasteurized donor human milk. I acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Financial Responsibility
MMBA is a non-profit organization providing donor human milk to premature and otherwise fragile infants, as well as other individuals' with a medical need. It is the desire of MMBA to provide donor human milk in a manner protective of the financial solvency and sustainability of the organization.

I understand that I am financially responsible to the MMBA for any charges not covered by health care benefits, including the shipping of milk, if applicable. I understand that failure to pay my bill in full or maintain regular contact regarding payment may lead to discontinuation of services. I understand that by signing this form I am accepting financial responsibility, as explained above, for all payments for services received.

Charitable Assistance
I am aware that the MMBA has a charitable assistance fund to provide milk to families with a medical need when attempts to acquire private or public insurance coverage have failed or the family lacks the financial means to cover the full costs of service. I am aware I must sign an Agreement for Services and complete an Application for Charitable Assistance in order to be considered. If I am not approved for Charitable Assistance I am responsible for payment in full. If I am approved for Charitable Assistance I must adhere to a payment plan or services may be discontinued.

Assignment of Benefits
I request that payment of authorized insurance benefits be made on my behalf to the agency listed below for services provided to me by that agency. In the event that I am reimbursed directly by my carrier I am responsible for submitting payment for services to the Milk Bank within 7-10 days of receipt and deposit of payment or my services may be terminated. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the agency, my insurance carrier, health care provider or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I do / do not (circle one) give my permission for the MMBA staff to leave a message on my home answering machine or with a family member at my home number.

AGENCY
Mothers' Milk Bank at Austin
5925 Dillard Circle
Austin, Texas 78752
877-813-6455

Parent One name _____

Date of Birth: _____

SSN:_____

Employer:_____

Work phone: _____

Parent Two name _____

Date of Birth: _____

SSN:_____

Employer:_____

Work phone: _____

Primary Insurance

Name of carrier: _____

ID#: _____

Group number: _____

Phone number: _____

Secondary Insurance

Name of carrier: _____

ID#: _____

Group number: _____

Phone number: _____

If no parent available, Name of Legal Guardian: _____

Relationship to Recipient: _____

Signature of Parent/Legal Guardian: _____

Date: _____