David Penner MD PLLC
Child, Adolescent and Adult Psychiatrist

Practice Policies and Agreement (10/2018)

Confidentiality
Patients who are 13 and older have the right to confidentiality under Washington State law.

Parents and other family members play a critical role in the treatment planning process. Nonetheless, if an adolescent requests that certain information be kept from their family I will help them with their issue and discuss ways to appropriately to involve their parents.

For those 13 to 18 who have requested that records be kept confidential, information will be disclosed without release only in cases in which there is suspected child abuse, danger to self or others, or other situations in which a child or adolescent may be putting themselves in a potentially dangerous situation (e.g. substance abuse).

Please note that if you choose to use your insurance for reimbursement your information will be shared in accordance with the agreement and policies set forth by your insurance company. Insurance companies always require type of service and diagnosis codes. I will inform you of any requests and how to handle them. As specific insurance company policy information is made available, I will share it with you.

Appointments
At the conclusion of a visit I will provide you with a card asking you to schedule your follow-up appointment within a specific time frame appropriate to your condition/ needs with my assistant on checking out. If any unforeseen issues arise please contact our office at 360 539 1736 to be seen sooner.

Cancellation Policy / Late Cancellations/ No Shows and Fees
Appointments that are missed without having notified my office at least 24 hours in advance will be charged at 50 percent of the full fee. Monday appointments must be cancelled by 4 p.m. the preceding Friday. Please note that insurance will not reimburse missed visits. More than three missed appointments or late cancellations (two if I have only seen you four times) may be grounds for termination of treatment

Voicemail/Messages
I will do my best to respond to messages within 48 hours. Calls left late on Friday will most likely be processed on Monday morning.

Emergencies
For life-threatening emergencies, please call 911 or go to your nearest emergency room. For other crises or urgent matters, call my office, leave a message, and follow the directions with regards to contacting me or the person who is providing coverage if I am away. If you cannot reach me during an urgent situation, you may also call the crisis line 24 hours a day, 7 days a week at 360.586.2800.

Telephone Calls
I provide face-to-face care, but urge families to call me regarding medication interactions or new behaviors that may be causing concern. In most cases, issues that cannot be handled with brief management or recommendations will require an office visit.

Child and adolescent psychiatry often entails significant time outside of scheduled meetings in order to contact, coordinate care and discuss treatments with teachers or other providers. I believe this work greatly increases the quality of care you or your child receives. For unusual or extensive phone calls outside of your typical visit needs (such as phone management significantly between appointments) or those exceeding 15 minutes are billed at my hourly rate of $375; I round to the nearest minute and do not charge for documentation time. Note that this is a rare occurrence.

Refills
In general, I provide as many refills as I believe is reasonable given the stability of the patient and frequency of monitoring needed. For refills, please have your pharmacy fax me a refill request form. If your condition requires monitoring and I have not seen you recently, I may insist on an appointment and will typically provide you with enough medication until the appointment. I do this in order to provide safe and appropriate care for you.

In most cases, visits are frequent upon treatment initiation, with the time between appointments lengthening as stability is achieved. Refills often follow that pattern as well. My standard of care is to see long term patients a minimum of every three months for safety and will instruct you at the end of your visit (by providing you with an appointment card) to schedule your next appointment at the appropriate follow-up length. Because active psychiatric conditions require monitoring as they evolve, if you fail to schedule and/or I have not seen you for 6 months, your psychiatric condition will not have been managed by me for

some time, and to reflect that your file will be formally closed and I will no longer be your psychiatrist of record, unless we have mutually made very specific plans to the contrary. If it is safe, stable, and clinically appropriate I will generally transfer care back to the primary care provider if that frequency of monitoring is not needed.

Patient Records

You may request copies of your medical records at your own expense and ask that factual errors be corrected. Parts of your record that could potentially be more detrimental than helpful to your psychological well-being, or that were asked to be kept confidential by the provider, may be withheld.

You may authorize in writing that copies of these records be released to entities you designate. Records sent to other mental health care providers, primary care providers, and therapists for purposes of education evaluation, psychological testing or other mental health treatment will be provided free of charge unless exceeding 100 pages, in which case a nominal fee will be charged. Records requested for personal or legal reasons will be charged standard rates per Washington State law.

Fees (as of 10/20/2018)

Psychiatric evaluation (60 minutes)	**$386.50**
Typical follow-up visit due at time of service (Level 4 complexity)	**$201.34**

Please note that due to regulations and guidelines set forth by the Centers for Medicare and Medicaid (rev 2013) and your insurer, actual rates vary in accordance to medical complexity and time spent on other activities during the visit. Many typical visits vary from L2, L3, L4, and L5 complexity and rates are $120, $136.60, $201.34, and $271.26 accordingly, Therapy brief with L3-L5 visit at $125.60, and Developmental screening, standardized test, with scoring and report $15. Rates typically follow those as defined by fees set forth by the Washington State Department of Labor and Industries. Current rates are posted on my website and will change.

Insurance and Payment

Because I am not contracted with most insurance plans, it is the patient's responsibility to verify whether their insurance will provide reimbursement. I provide statements detailing my services using the most appropriate insurance-billable codes; however, some of my services may not be covered by insurance.

For some insurance companies, I offer courtesy submission of claims on your behalf (see insurance form). Payment for services, including those not covered by insurance, is the patient's responsibility. If you choose not to seek reimbursement from you insurance, you may wish to have visits and evaluations condensed.

I am not in network or a participating provider for Medicare, Medicaid or Tricare and cannot bill them or submit any claims for any service. Secondary copays cannot be billed to these insurers. (Though can often be recouped from Tricare)
You submit for reimbursement from Tricare yourself, and I will be happy to assist in this process by providing industry standard HCFA/ CMS-1500 forms and any supporting statements/ receipt either at the time of appointment or afterwards. Copayments are due prior to generation of the forms. If you are a Tricare/CHAMPUS beneficiary by signing these policies you explicitly agree to the listed fees above, or the standard in network rates, copays and deductibles of your primary commercial insurance carrier contracted with Dr. Penner even if exceeding 115 percent of Tricare fee schedules. If you are eligible for **Medicare** you agree that this document serves a private contract with Dr. Penner, who is excluded from Medicare. You accept full responsibility for payment of all charges and Medicare limits on charges do not apply. Furthermore you will not seek reimbursement from or submit claims to Medicare, nor will Dr. Penner. Additionally Medigap plans will not pay for services not covered by Medicare (Dr. Penner's services. You acknowledge that no payment will be made by Medicare that would otherwise have been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted. You enter this contract knowing your right to obtain Medicare-covered items and services from practitioners who have not opted out of Medicare, and you are not compelled to enter into private contacts that apply to other Medicare-covered services from other physicians who have not opted out. The expected opt out period is indefinite. If your treatment is under a Labor and Industries or Crime Victims compensation claim, you agree that as per required by both programs, that your treatment records will be shared with the respective programs and / or claim managers.

If you choose to utilize insurance for payment, you agree to be bound by your insurance company's regulations regarding their access to your medical records for quality assurance and audit, for appropriateness of care and documentation of services provided to you. As part of your agreement with your insurer, they may audit my records to determine if I have provided the services submitted to them. Because of the complexity of insurance coding, any necessary covered in network services outside of appointments (such as test scoring, unusual phone calls, or extensive review of records) will be billed to your insurer at their established definitions and allowable rates. Very rarely for in network services when an unusual extended session is required, the appropriate in network "extended session" codes such as first additional hour (defined as 30-74 min), and then subsequent 30 minute increments will be billed at usual 25-30 min medication visit rates. You are also responsible in determining and verifying if an authorization for care is needed.

In split-custody situations, the parent initiating treatment is ultimately responsible for payment.

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Claims Submission
By providing me with your insurance information you agree to authorize me to submit claim forms on your behalf for out-of-network benefit reimbursement directly to you after services are provided. You also agree to be subject to your insurance company's contract regarding the need to exchange information necessary for billing and in accordance with their procedures.

Billing
I automatically bill face-to-face services on the day they are rendered; other services are billed at the end of the month. I submit claims for most major insurances for your reimbursement.

Unless contractually agreed upon, payment is due at the time of service, or a credit card may be kept on file for automatic payment. I currently accept checks, cash, Visa, MasterCard, American Express and Discover. Payment is due at time of service for out of network services, and usual copays. If there is an outstanding balance due to deductibles, a payment of 40 dollars or 10 percent of the maximum outstanding bill balance (whichever is greater) is required every month, but only if arranged on contract. Due to overhead requirements, if payments are >60 days late without notice to us, accounts will be forwarded to collections. If outstanding balances are not paid and not addressed, treatment information may be released for collection agency involvement. If the undersigned fails to pay for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection costs, court fees and including attorney's fees.

Insurance Codes
Below are CPT codes (standard insurance descriptors) that I bill. I am knowledgeable about reimbursements and bill for the highest level that is appropriate; however, variations exist depending on specific insurances.

The most common codes are below. If your insurance does not cover the codes listed in bold, it is likely they will cover one of the other codes, but at a lower rate. If you wish to ask your insurer what they will reimburse for, they may wish to know my Tax Identification Number (275362332) and NPI (1114005584). A common "diagnosis" code used is unspecified episodic mood disorder (F39), attention deficit hyperactivity disorder (F90.9) or anxiety disorder unspecified (F41.9) . That information should be sufficient for your insurance to advise you. Since I have submitted claims to many insurers they should be able to provide you with a clear answer of what they will reimburse you.

<u>Most commonly used codes</u>
99205 (New patient evaluation), 99213, 99214, 99215 (followup office visit L3-L5 complexity) with or without 90833 (therapy brief with L3-L5 visit).

<u>Others codes</u>
99441, 99442, 99443 (telephone calls 5-30 min), G0451 Standardized test interpretation and scoring (ADHD, Autism, Depression scales etc,) 99354 (extended session first 30-74 min beyond usual service), 99355 (even further extended session each 30 minutes), 90832,90834, 90837 (psychotherapy 30, 45 and 60 min), (with medications 90833, 90834 and 90838 respectively)

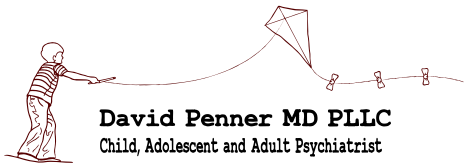
Agreement
I have read the above practice policies and have had the opportunity to have my questions answered. I understand that policies and fees change over time and that I will be updated regarding any major adjustments.

I have read and acknowledge receipt of David Penner, MD, PLLC's notice of privacy practices at www.davepennermd.com and have had my questions answered.

I consent to evaluation and treatment by Dr. Penner and agree to be responsible financially for services rendered.

Patient (if 13 or older)	Parent (if of minor child)	Date

Name of patient



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Insurance Demographics (Rev 11/2017)
I am currently in network for Kaiser / Group Health (with preauthorization), Regence BlueShield, Premera Blue Cross, Aetna, Lifewise, HMA, FEP Blue, many out of state Blue Cross Blue Shield programs and any First Choice plan which processes mental health through First Choice directly (not a mental health "carveout"). Submission on your behalf for "out of network benefit" claims is currently available for Cigna, Carpenter's, and any provider listed at https://www.officeally.com/payerList.aspx without a "pre-enrollment" requirement. Please see practice policies regarding payment and determining your out of network benefits.
For online version of this form (preferred) please click here: https://www.davepennermd.com/Insurance___Demographics.html

Patient's name:

Date of Birth:

Address:

Home phone number:

Marital status:

Insurance Company:

Insurance Company Payor ID or EDI number (only if on back of card):

Does back of card list any separate information or phone numbers for mental health or substance abuse?

IF SO, IT IS YOUR RESPONSIBILITY TO VERIFY/ CONTACT YOUR INSURANCE AS WE MAY BE OUT OF NETWORK. (Your mental health benefits may have been "carved out" to a completely separate company than your medical benefits)

Employer's Name or School Name:

Insurance Plan Name or Program Name:

Insurance Card ID Number:

Insurance Policy Group or Number:

For patient's on another person's insurance policy (children/ spouses)
(may omit if duplicate from above)

Primary Insured's Name:

Primary Insured's Date of Birth:

Primary Insured's Address:

Primary Insured's Home phone number:

Primary Insured's Marital status:

Primary Insured's Employer or School Name:

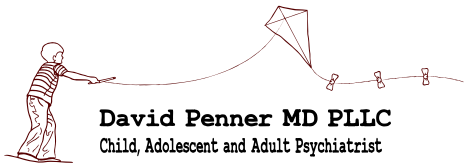
I authorize Dr Penner to submit claim forms to my insurance company on my behalf for reimbursement directly to me after services are provided I agree to be subject to my insurance company's contract with regard of the need to exchange information necessary for billing and in accordance with their procedures. I understand that Dr Penner may submit claims as a courtesy to me. I understand it is my responsibility to verify coverage and that Dr Penner will provide me with any rejected claim forms and billing information for me to followup with and directly submit to my insurance company. I agree to be responsible financially for services rendered to me.

_____ _____ _____
Patient Parent (if applicable) Date

Email address:_____
Would you like to receive appointment reminders via email? ☐ Yes ☐ No

Please note, due to privacy, we do not use email routinely but under emergent circumstances may need to send you a "we cannot reach you by phone, please call our office" message if a scheduling issue comes up or you elect to receive reminders.

p: 360 539 1736 f: 360 350 5610
mail: PO Box 23, Olympia, WA 98507-0023
office: 324 West Bay Dr NW #214, Olympia WA 98502 **www.davepennermd.com**



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IF YOU WISH TO KEEP A CREDIT CARD ON FILE FOR AUTOMATIC PAYMENT OF COPAYS

Patient Name:_____ Date of Birth _____
First Middle Last

Billing Information:

Accountholder Name:_____

Account Billing Address _____

_____

City_____ State_____ Zip _____

Account Phone _____

Card # _____

Exp: _____/ _____ Security Code on Back of Card (3 or 4 digit) _____

Email if you would like receipts: _____

Card on File Agreement **Payment on file / automatically deleted on expiration of card.**
Not to exceed: $375.00 for any single charge

I hereby authorize David Penner MD PLLC to keep my account information on file for payment and to initiate debit or charge entries on this account as amount are owed for the Patient Account listed above. I acknowledge that the origination of ACH or credit card transactions to my account must comply with the provisions of U.S. law. I understand that a debit or charge may be made to my bank account or credit card account periodically to pay for amounts owed. If my bank account or credit card information listed above changes for any reason, I will notify David Penner MD PLLC. This authorization shall remain in effect until **the end date as listed above** or until David Penner MD PLLC has received written notification from me of its termination..

X_____ Date: _____

cardholder

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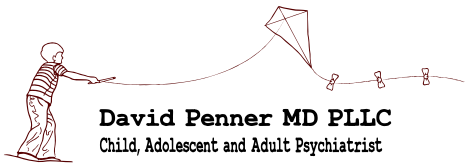


David Penner MD PLLC
Child, Adolescent and Adult Psychiatrist

AUTHORIZATION TO OBTAIN, USE AND DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME:_____
Last First Middle

Home address:_____

Home telephone:_____ Date of Birth: _____

I authorize David Penner MD and the named party below to exchange written and verbal information including my protected health information, including medical treatment, mental health treatment, educational information for the purpose of providing psychiatric assessment, diagnosis, treatment or coordinating care unless specified otherwise below.

PRIMARY CARE PHYSICIAN: _____

Address:_____City:_____

State:_____ZIP:_____Phone:_____Fax:_____

INFORMATION COVERED UNDER THIS RELEASE

____ Entire medical record (Examples include discharge summaries, medical assessments, lab data and information from a primary care physicians office)

____ Ongoing communication regarding psychiatric or mental health care (Examples include ongoing care with a primary care physician or mental health provider)

____ Individual Education Plan, school psychological testing, and information relating to the academic performance and behavior of child in a school setting.

____ Psychological testing

____ Information for referral purposes

____ Other (please specify)_____

____ Specific authorization for information related to testing, diagnosis and treatment for drug or alcohol use.

____ Specific authorization for information related to testing, diagnosis and treatment of sexually transmitted diseases or HIV

The purpose of this disclosure is: Medical care_____ Legal Matter_____ Insurance_____ Personal:_____

TERM: Unless otherwise specified this authorization will expire on termination of treatment with Dr Penner or if for a minor, the time at which the minor reaches age 13.

This authorization expires :

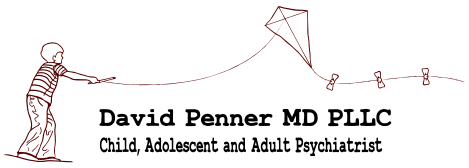
_____ Termination of treatment with Dr Penner or if a minor reaches age 13. (Default)
____ 90 days from the date signed
____ on other date, reason or event (specify) _____

By my signature below, I hereby authorize David Penner MD to obtain, use and/or disclose my health information for the term of this Authorization for the specific purposes listed ("At the request of the patient" is sufficient if the patient is initiating this Authorization).
I understand that once David Penner MD discloses my health information to the recipient, David Penner cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of Dr Penner's treatment of me; except, however, if my treatment by Dr Penner is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Dr Penner may refuse to treat me if I do not sign this Authorization. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to David Penner. the revocation will be effective immediately upon David Penner's receipt of my written notice, except that the revocation will not have any effect on any action taken by David Penner in reliance on this Authorization before it received my written notice of revocation

I have read and understand the terms of this authorization and have had an opportunity to ask questions about obtaining, using and disclosing my health information. By my signature below, I hereby, knowingly and voluntarily authorize David Penner to obtain use and/or disclose my health information in the manner described above.

X_____X_____X_____
Signature of Patient or Personal Representative Relation to patient (self, guardian, parent etc) Date

p: 360 539 1736 f: 360 350 5610
mail: PO Box 23, Olympia, WA 98507-0023
office: 324 West Bay Dr NW #214, Olympia WA 98502 **www.davepennermd.com**



David Penner MD PLLC
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AUTHORIZATION TO OBTAIN, USE AND DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME:_____
Last First Middle

Home address:_____

Home telephone:_____ Date of Birth: _____

I authorize David Penner MD and the named party below to exchange written and verbal information including my protected health information, including medical treatment, mental health treatment, educational information for the purpose of providing psychiatric assessment, diagnosis, treatment or coordinating care unless specified otherwise below.

THERAPIST: _____

Address:_____City:_____

State:_____ZIP:_____Phone:_____Fax:_____

INFORMATION COVERED UNDER THIS RELEASE

____ Entire medical record (Examples include discharge summaries, medical assessments, lab data and information from a primary care physicians office)

____ Ongoing communication regarding psychiatric or mental health care (Examples include ongoing care with a primary care physician or mental health provider)

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____ Psychological testing

____ Information for referral purposes

____ Other (please specify)_____

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This authorization expires :

_____ Termination of treatment with Dr Penner or if a minor reaches age 13. (Default)
____ 90 days from the date signed
____ on other date, reason or event (specify) _____

By my signature below, I hereby authorize David Penner MD to obtain, use and/or disclose my health information for the term of this Authorization for the specific purposes listed ("At the request of the patient" is sufficient if the patient is initiating this Authorization).
I understand that once David Penner MD discloses my health information to the recipient, David Penner cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of Dr Penner's treatment of me; except, however, if my treatment by Dr Penner is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Dr Penner may refuse to treat me if I do not sign this Authorization. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to David Penner. the revocation will be effective immediately upon David Penner's receipt of my written notice, except that the revocation will not have any effect on any action taken by David Penner in reliance on this Authorization before it received my written notice of revocation

I have read and understand the terms of this authorization and have had an opportunity to ask questions about obtaining, using and disclosing my health information. By my signature below, I hereby, knowingly and voluntarily authorize David Penner to obtain use and/or disclose my health information in the manner described above.

X_____X_____X_____
Signature of Patient or Personal Representative Relation to patient (self, guardian, parent etc) Date

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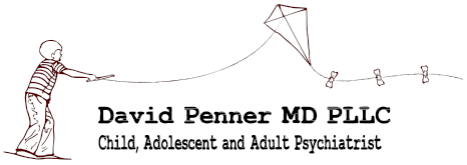

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Please bring all copies of outside records, psychological testing, individualized education plan documents, evaluations and other relevant materials in your possession to your initial visit. This information helps me assess the needs of your child or adolescent and guides my treatment recommendations. You may fill this form out and bring it to your initial appointment or you may fax it to 360.350.5610 prior to your appointment.

HISTORY AND BACKGROUND INFORMATION

DEMOGRAPHICS

Child/Adolescent's Name _____ _____ _____
Last First Middle

_____ _____ _____ _____
Date of Birth Age Sex Birthplace

_____ _____ _____ _____
Home address City State Zip

_____ _____ _____ _____
Mailing address if different City State Zip

_____
Email address (for emergencies only)

Please note, due to privacy, we do not use email routinely but under emergent circumstances may need to send you a "we cannot reach you by phone, please call our office" message if a scheduling issue comes up or you elect to receive reminders.

Please select how you would like to receive appointment reminders. You may choose multiple options:

Text☐ _____ Email☐ Phone Call☐ _____

Please note, automated reminders are provided as a courtesy. Missed appointments are under 24 hour cancellations will incur a cancellation / no-show fee.

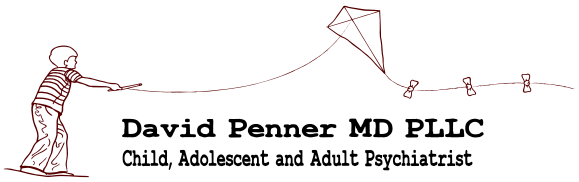
Phone / Name of Emergency Contact	Relationship to Patient	Type of Phone (Home/ Work/ Cell)	Okay to leave message? (Non-emergencies/ Routine)

Phone / Name of Emergency Contact	Relationship to Patient	Type of Phone (Home/ Work/ Cell)	Okay to leave message? (Non-emergencies/ Routine)

Who Referred You to Me? _____

Briefly, what is the primary reason for consultation/evaluation? (Concerning behaviors, sadness, learning problems, peer problems, etc.)

Name of person completing this form and relationship to child:



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MENTAL HEALTH HISTORY

HOSPITALIZATIONS FOR PSYCHIATRIC REASONS (if applicable) ☐ **N/A**

Please list all hospitalizations your child or adolescent has had, the dates, where and what for:

COUNSELING OR THERAPY SERVICES (if applicable) ☐ **N/A**

Please indicate any current or past counseling or therapy sessions your child or adolescent has had, and if so, with whom, when, for how long, and what for? Are you happy with the treatment (if current)

PAST PSYCHIATRIC MEDICATIONS (if applicable) ☐ **N/A**

Please list any psychiatric medications your child or adolescent has taken.

Name Dose (if known) What for ? Effective? Side-effects?

Please indicate any other mental health treatment outside the usual scope of usual 'medical' practice
(holistic treatments, church counseling, alternative treatments, dietary treatments, etc.)

Do you know, or have suspicions, that your child or adolescent has been physically, sexually, or verbally abused?
☐ Yes ☐ No If Yes Please explain:

Are you concerned or suspicious that your child or adolescent might be using tobacco products, alcohol, marijuana or other drugs?
☐ Yes ☐ No If Yes Please explain:

Has your child or adolescent ever attempted suicide or voiced thoughts about it?
☐ Yes ☐ No If Yes Please explain:

Has your child or adolescent ever engaged in cutting or other self-injurious behaviors?
☐ Yes ☐ No If Yes Please explain:

Has your child or adolescent ever said he/she hears voices that other people don't hear or sees things other people don't see?
☐ Yes ☐ No If Yes Please explain:

Does your child or adolescent complain about physical ailments more than you would expect?
☐ Yes ☐ No If Yes Please explain:

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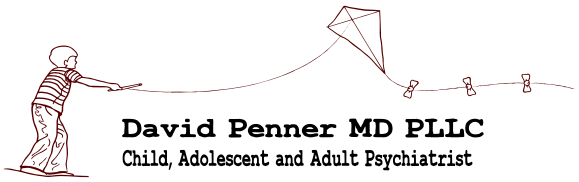

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MEDICAL INFORMATION

Allergies_____ ☐ (no known allergies)

Name and location of Pediatrician/Primary Care Provider:_____ _____
(name) (city/location)

Has your child or adolescent had any medical problems, medical hospitalizations or surgeries? Please list any:

_____

Does your child or adolescent currently take prescribed medications, over-the-counter medications, or supplements? If so please list:

Name	Dose (if known)	What for ?	Effective?	Side-effects?

Has your child ever had any of the following:

History of fainting or passing out	☐ Yes	☐ No
Heart murmurs	☐ Yes	☐ No
Heart abnormalities	☐ Yes	☐ No
Heart arrhythmia	☐ Yes	☐ No
Abnormal findings on an EKG (electrocardiogram)	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Meningitis	☐ Yes	☐ No
Head injuries	☐ Yes	☐ No
Is there a history in the child's family of sudden unexplained early deaths?	☐ Yes	☐ No

FAMILY COMPOSITION Parent(s) Are: ☐ Partnered/ Married ☐ Single ☐ Separated ☐ Divorced

Parent _____ _____ ____ _____
(name) (occupation) (age) (present health)

Parent _____ _____ ____ _____
(name) (occupation) (age) (present health)

Please list all biological siblings below.

Name	Age	(Brother/Sister/Step-)	At Home?	Grade

Please list the names and relationships of foster parents, adoptive parents, or step-parents below, as applicable:

p: 360 539 1736 f: 360 350 5610
mail: PO Box 23, Olympia, WA 98507-0023
office: 324 West Bay Dr NW #214, Olympia WA 98502

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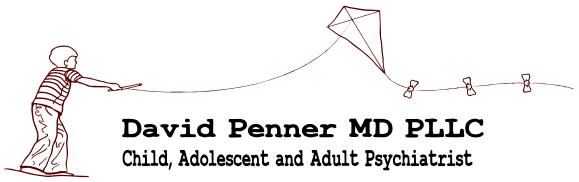

David Penner MD PLLC
Child, Adolescent and Adult Psychiatrist

FAMILY MENTAL HEALTH HISTORY

Has anyone in the child's immediate or extended family ever been diagnosed with a psychiatric illness, had a psychiatric hospitalization or suicide attempt, or struggled with issues involving drugs or alcohol? Please provide information about psychiatric medications taken if known: *(Please note that this information is highly confidential. I am asking these questions because the answers may help determine genetic risks. Additionally, responses to medications may run in families and this knowledge may help guide treatment. Examples of conditions are depression, anxiety, PTSD, ADHD, autism, OCD, schizophrenia, bipolar disorder, alcoholism or other substance dependence.)*

DEVELOPMENTAL AND BIRTH HISTORY

Duration of Pregnancy: _____months.

Did mother smoke during pregnancy? ☐Yes ☐No
Consume alcohol? ☐Yes ☐No
Was the baby discharged on time from the hospital? ☐Yes ☐No
When did your baby begin to walk? _____
When did your baby begin to say first words? _____
When did your baby begin to say phrases or sentences? _____
Did your baby appear to engage in appropriate play with similar-aged children? ☐Yes ☐ No
Did your baby receive early intervention services? ☐Yes ☐ No
Did your baby avoid eye contact? ☐Yes ☐ No
Did anyone express any concern about how your baby was developing? ☐Yes ☐ No

If Yes to any of the above, please provide details

SCHOOL INFORMATION

Name of School _____ Grade _____ City _____

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Has your child complained of or have you noticed any of the following:

Fatigue?	☐ No ☐ Yes:
Changes to vision?	☐ No ☐ Yes:
Changes to hearing?	☐ No ☐ Yes:
Palpitations/Chest Pain/Dizziness?	☐ No ☐ Yes:
Shortness of breath?	☐ No ☐ Yes:
Nausea or vomiting?	☐ No ☐ Yes:
Frequent urination?	☐ No ☐ Yes:
Muscle or joint pain?	☐ No ☐ Yes:
Rashes?	☐ No ☐ Yes:
Dry mouth?	☐ No ☐ Yes:
Headaches?	☐ No ☐ Yes:
Increased or decreased sweating?	☐ No ☐ Yes:
Easy bruising or bleeding?	☐ No ☐ Yes: