

Genuine Life Psychology & Wellness, PLLC

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Jennifer S. Hartman, Ph.D.

Licensed Psychologist, Owner

Basic Information

Full Legal Name _____ Date of Birth _____

Complete Mailing Address _____

May I send mail to this address? Yes No

Home Phone _____ May I leave a detailed message at this number? Yes No

Cell Phone _____ May I leave a detailed message at this number? Yes No

Your email address: _____

Emergency Contact: Name/relation _____ Phone _____

Who referred you to my practice? _____ May I thank them? Yes No

Please provide the following contact information to allow me to collaborate with your health care team, under the terms outlined on the "Patient Agreement and Consent to Treatment form:"

Primary Care Physician _____ Phone Number _____

Psychiatrist _____ Phone Number _____

Other Health Professional _____ Phone Number _____

Acknowledgment of Consent and Policy Statements

By initialing and signing this agreement, you are indicating that you have read completely all of the documents listed below and have had all of your questions answered. You agree to the provisions and policies freely and consent to treatment with Jennifer S. Hartman, Ph.D, Genuine Life Psychology & Wellness, PLLC. Any changes must be signed by both parties. You have a right to keep a copy of this contract.

- 1. Patient Agreement and Consent to Treatment _____ **Patient Initials**
- 2. Technology & Electronic Communication Policy _____ **Patient Initials**
- 3. Scheduling & Attendance Policy _____ **Patient Initials**
- 4. Billing & Insurance Policy _____ **Patient Initials**
- 5. HIPAA Notice of Privacy Practices _____ **Patient Initials**

Would you like to receive biweekly email newsletters with my blog posts and practice updates?* Yes No

*For more information about these emails, please review the Technology & Electronic Communication Policy

Patient Signature _____ Date _____

Printed Name _____

Therapist Signature _____ Date _____
Jennifer S. Hartman, Ph.D.

If applicable:
Legal Parent or Guardian Signature _____ Date _____

Relationship to Patient _____