Genuine Life Psychology & Wellness, PLLC
8340 Meadow Road, Suite 224, Dallas, TX 75231
Phone 972.742.2186 | Fax 469.232. 9943

Jennifer S. Hartman, Ph.D.
Licensed Psychologist, Owner

Basic Information

Full Legal Name____ Date of Birth____________________

Street Address____City, State, Zip________________________

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 twice monthly 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_____________________________________

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