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 Agreement, Authorization & 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, Authorization, & 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 withmy 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_____