

**Lisa Annulis, LCSW-C, SAP, SAE**  
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Welcome to the office of Lisa Annulis, LCSW-C, SAP, SAE. Please follow the instructions for your appointment:

1. When you come into the building, come up the stairs and to the right are bathrooms. The waiting area right outside the bathrooms are the black and white chairs and tables. Don't follow the signs to suite #311.
2. If you are completing paperwork **at the office** come in 15 minutes early for your appointment. Look for a clip board on one of the black and white chairs with your initials on it. Complete the paperwork and I will come out to get you at the time discussed.
3. If you are completing the paperwork **prior to our appointment**, please bring all forms with you and have a seat in the black and white chairs as noted above. I will come out to get you at the discussed time.

**PLEASE DO NOT KNOCK ON THE DOOR TO MY OFFICE WITH MY NAME ON IT. THE OFFICE IS A ONE ROOM SUITE.**

4. The forms include:
  - a. INTAKE FORM Page 2  
Complete all information that applies to your situation. If you are unsure leave it blank.
  - b. HIPAA Notice Page 3-5  
Please review and sign page 5. I will make a copy for you if you request it.
  
- a) INITIAL QUESTIONNAIRE Page 6

**Please bring a copy of your insurance card and ID with you.**  
**I look forward to helping you.**

**INTAKE FORM THERAPY**

Referral Source: \_\_\_\_\_ Date \_\_\_\_\_

Date of Intake \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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**INSURANCE**

Name Insurance: \_\_\_\_\_

Primary Insurance Name/DOB if different from client: \_\_\_\_\_

Phone# Providers: \_\_\_\_\_

ID/Group#: \_\_\_\_\_

Deductable/Copay: \_\_\_\_\_

Plan Year Star Date: \_\_\_\_\_

Address Claims: \_\_\_\_\_

Do Not Write Below This Line

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HIPAA  
Signed: \_\_\_\_\_

Release of  
Information: \_\_\_\_\_

Other: \_\_\_\_\_

**THERAPY AGREEMENT**  
**AND HIPAA NOTICE OF PRIVACY PRACTICES**

Welcome to my office. I have the responsibility to give you the best care possible, to respect your rights, and to recognize your responsibilities as a client. Please read the following to identify your rights and responsibilities.

1. Services provided—This agreement documents and describes the services rendered including individual assessment, individual and couples. Individualized assessment will occur in the first 1-3 sessions with ongoing assessment thereafter. I will send an email with a summary of our session when we meet and homework to focus on in-between sessions.

2. Notice of Right to Privacy and Confidentiality—Confidentiality is maintained as part of the therapy process in accord with generally accepted ethical standards. Your written authorization is required for any release of information or records. Information can be exchanged in various forms at your request i.e. written, verbal, telephone, fax, and/or E-mail. Measures are taken to ensure confidentiality and maintain federal, state and local regulations. Exceptions are made to this policy only in the following circumstances:

I am a mandated reporter, which means that if I have knowledge of, or reasonable cause to believe, that a child is being neglected or abused I must, and will, report this to a state/local agency.

If someone threatens to hurt himself or herself, or someone else, and in my professional judgment I believe there is a safety concern, I will take the necessary steps to protect you or the other person.

3. Non-discrimination—You have the right to not be discriminated against in the provision of professional services on the basis of race, age, gender, ethnic origin, disabilities, or sexual orientation.

4. Right to Professional Disclosure—You have the right to ask me what my training is, where I received it, my professional competencies, experience, education, and other relevant information that may be important to you in the provision of services. I am licensed to practice in Maryland as a Licensed Clinical Social Worker. You have the right to examine public records maintained by the State Maryland Licensing Board of Social Workers. I subscribe to the Code of Ethics of the National Association of Social Workers.

4. CON'T Resume and Training Summary are available upon request. If a conflict occurs in the course of the counseling relationship, I prefer to discuss this with you as part of the counseling process. If there is a complaint or you are dissatisfied, I would request that you discuss the issue with me. If I am not able to resolve the concerns, you have the right to contact the appropriate licensing agency.

5. Right to Professional Recommendations, Opinions, and Referrals—You have the right to be informed of my assessment of the presenting problem(s) and to know available treatment alternatives. You also have the right to understand the purpose of professional services, including an estimate of the number of therapy or consultation sessions, the expected length of time involved, the cost of the services, the method of treatment, and the expected outcomes of therapy. You have the right to consent to or refuse recommended treatment, and to obtain referrals for other specialized services.

6. Appointment Responsibilities—Your appointments are reserved for you. **You will be charged \$54 for any cancelled appt. and if you fail to cancel within 48 hours that will go up to your full fee rate for day of cancellations.**

7. Financial Responsibilities—I am willing to bill your insurance for services and all copay and deductibles are your responsibility and due in full. Please be advised that insurance companies require a diagnosis to reimburse. You have the right to know what your diagnosis is.

Individual sessions are generally scheduled once a week for (50) minutes. The fee for this standard session is \$180, unless otherwise arranged.

8. Training and Professionalism—As a licensed social worker I am required to participate in continuing education. This is not only to maintain my licenses, but also to continue my growth as a therapist and for the benefit of my clients. In addition to continuing education, I am committed to seeking consultation and supervision in my practice as needed. I seek and provide advanced training and education. All identifying information will be disguised if used for training or education purposes. Confidentiality standards are maintained through this process as well.

9. Crisis Services—My practice is not emergency or crisis oriented. Please note that there are times when I will not be available. If this is a concern for you, please discuss this with me. If you are having an emergency, please call 911.

10. Termination of therapy should be a mutual decision and discussed prior to termination of services.

**THERAPY AGREEMENT AND HIPPA NOTICE OF PRIVACY PRACTICES**  
**Continued**

***PRINT THIS PAGE AND SIGN***

By signing this form, you have read, understand, and agree to the  
aforementioned terms.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

I have confirmed with the client, that they have no further questions and wish to  
precede with treatment.

Lisa Annulis, LCSW-C, SAP, SAE: \_\_\_\_\_ Date: \_\_\_\_\_

