Client Name: _____

No Surprise Billing Protection

Good Faith Estimate

Out of Network Provider Name: HOPE EVERGREEN LLC

A diagnosis code is required by insurance to obtain reimbursement for services. Client is diagnosed following the Initial Psychiatric Diagnostic Evaluation. Ask your provider about your diagnosis following your initial assessment. You may request a superbill for out of network services, which includes the diagnosis of the client for reimbursement purposes. By using your insurance, you are consenting to the release of this information to your insurance company. You may choose to not be diagnosed when you are self-pay; however, you will not be able to receive reimbursement for services from your insurance company without a diagnosis.

Katheryn McLendon LCSW-S

90791	Intake / Individual (90 min)	$200
90837	Individual (60 min)	$180
90834	Individual (45 min)	$160
90847/90846	Family (45 min)	$160
00000	No Show	$100

The estimate for a NEW self-pay client is based on the rate of $180 each 60 minute session held twice a month over the course of 12 months. The total cost for treatment would be no more than $ 4,680. *This amount is only an estimate; it is not an offer or contract for services*.

Dianna Neal LCSW

90791	Intake	$180
90837	Individual (60 min)	$160
90834	Individual (45 min)	$130
90847/90846	Family (45 min)	$130
00000	No Show	$100

The estimate for a NEW self-pay client is based on the rate of $ 130 each 45 minute session held twice a month over the course of 12 months. The total cost for treatment would be no more than $ 3,380. *This amount is only an estimate; it is not an offer or contract for services*.

Client Name: _____

Allison Rogers LCSW

90791	Intake	$180
90837	Individual (60 min)	$160
90834	Individual (45 min)	$130
90847/90846	Family (45 min)	$130
00000	No Show	$100

The estimate for a NEW self-pay client is based on the rate of $ 130 each 45 minute session held twice a month over the course of 12 months. The total cost for treatment would be no more than $ 3,380. *This amount is only an estimate; it is not an offer or contract for services*.

Shamicka Cannon LMSW*

90791	Intake	$120
90834	Individual (45 min)	$100
90847/90846	Family (45 min)	$100
00000	No Show	$100

The estimate for a NEW self-pay client is based on the rate of $ 100 each 45 min session held twice a month over the course of 12 months. The total cost for treatment would be no more than $ 2,600. *This amount is only an estimate; it is not an offer or contract for services*.

*Services provided under the supervision of Katheryn O. McLendon LCSW

Please see the full fee schedule for a list of all services and fees.