

**MARK S. DEBORD, LCSW, LLC
212 CYPRESS STREET
WEST MONROE, LA, 71291
318-381-9070
FAX: 318-322-1477**

**Provider Name License/#: Mark S DeBord, LCSW #1947
Provider Address: 212 Cypress St, West Monroe, LA 71291
Provider Phone #: (318) 381-9070
Provider Tax ID# (if applicable): Provider NPI # (if applicable):
Patient Name:
Patient Date of Birth:
Patient Address (include if telehealth):
Primary Diagnosis and Diagnosis Code: unknown until evaluation is complete (available upon request)**

**Services Requested: behavioral health services
Date of Initial Session:**

You are entitled to receive this Good Faith Estimate of what the charges could be for behavioral health services provided to you. While it is not possible for a clinical social worker to know, in advance, how many sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of sessions and types of sessions you attend that are mutually agreed upon to meet your individual circumstances.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. There may be additional items or services I may recommend as part of your care that must be scheduled or requested separately and are not reflected in this Good Faith Estimate. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means \$400 or more beyond the estimated charges). You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS).

If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

For questions or more information about your right to a Good Faith Estimate or the dispute resolution process, visit <https://www.cms.gov/nosurprises/consumers> or call 1- 800-985-3059. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you. For regular/recurring services such as psychotherapy you can provide a single GFE for the entire year as long as the estimate includes the expected scope of primary services including frequency, fee per visit and anticipated timeframe. There is no penalty to overestimate the charges. The GFE can only include recurring services that are expected to be provided within 12 months. The clinician must offer a new estimate for additional services beyond 12 months and discuss any changes between the initial and new GFE.

I anticipate your treatment will require [weekly, bi-weekly, every 3 weeks, monthly or longer, if determined appropriate] 45-60 minute psychotherapy sessions throughout the next 12 months at \$85-\$110 respectively per session. The number of sessions recommended will depend on presenting problem, comorbid problems, social support, personal progress with services and many other possible factors. Therefore, the specific number of sessions cannot be estimated precisely. Diagnostic session is billed at \$135. (If you are receiving couples services, the charge is \$110 per session with one diagnostic session billed at \$135.) As an example: if costs were \$110 per visit and you attended 16 sessions, your total cost is estimated at \$1760. If you attend more sessions than 16, the cost would accordingly higher. The frequency of sessions generally begins at once per week x 4-6 and then is reduced to every 2 weeks for 4-6 and then monthly, but this is always a mutual decision between provider and client.

In situations requiring ongoing weekly service, (52 weeks of service/ sessions) the total cost is estimated to be \$5200 (assuming an average cost of \$100 per session).

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of sessions. The number of sessions that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your provider. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Date of this Estimate:

Fee Schedule:

90791 Diagnostic Session - \$135

90832 30 minute session - \$60

90834 45 minute session - \$85

90837 60 minute session - \$110

90839 Crisis – first 60 minutes – \$110

90840 Crisis – each additional 30 minutes - \$55

90846 – Family without pt present - \$110

90847 – Family/Couple - \$110

Report preparation - \$100

Legal consultation or time in court - \$100 per hour