Victoria Plastic Surgery Center, Inc.

Cosmetic and Reconstructive Plastic Surgery

Yongsook Victoria Suh, M.D.
Diplomate, The American Board of Plastic Surgery
Member, The American Society of Plastic Surgeons

Prosperity Medical Center
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PATIENT INSURANCE INFORMATION

Reason for Visit: _____ Referred By: _____

Name: _____ DOB: _____/_____/_____
Last First MI Month Date Year

Address: _____
City State Zip

Primary Insurance Billing Information

In. Co. Name: _____ ID Number: _____

Group Name: _____ Group Number: _____

Address: _____
City State Zip

Subscriber's Name: _____

Subscriber's Date of Birth: _____/_____/_____ Subscriber's SSN #: ___-___-____
Month Date Year

Secondary Insurance Billing Information

In. Co. Name: _____ ID Number: _____

Group Name: _____ Group Number: _____

Address: _____
City State Zip

Subscriber's Name: _____

Subscriber's Date of Birth: _____/_____/_____ Subscriber's SSN #: ___-___-____
Month Date Year

Person Responsible for Account if other than Yourself

Name: _____ Relation: _____ SSN#: _____

Home #: _____ Work #: _____ Ext: _____ Driver's License:

Billing Address: _____

Employer: _____

Payment Policy

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office. In the event my account is turned over to an attorney for collections, I will pay any fee/costs incurred during the collection process.

Insurance Authorization and Assignment

I hereby authorize Victoria Plastic Surgery Center to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurances.

I understand that I will be responsible for a charge of $50.00 for missed appointments without at least 24 hour prior cancellation notice and a charge of $150.00 for any missed surgery/procedure without at least 2 weeks prior cancellation notice; and a $10 processing fee will be charged if I do not pay my copay at the time of my visit. I certify that the information I provided above is correct.

_____ _____
Date **Signature of Subscriber or Beneficiary**

_____ _____
Date **Signature of Patient**