Preterm
12000 shaker boulevard
cleveland, ohio 44120
phone 216.991.4000
preterm.org

Assignment of payment (Cash)

I, _____ agree to allow the person named below to
Patient Name
provide payment for my services at Preterm in the amount of $_____. I understand and agree that should any portion of this payment be refunded, it will be refunded to the payer named below. I will not receive a refund of any portion of this payment.

_____ _____
Patient Signature Date

I understand that payment of fees to Preterm for services rendered does not grant me access to any protected health information about any patient. No information about this patient will be furnished to me. I understand that photo ID will be required for the receipt of any refund for services not rendered. No refund will be issued for services rendered.

_____ _____ _____
Payer Name Phone Number
_____
Address (if different from ID)

_____ _____
Payer Signature Date

A legible copy of the payer's ID must accompany this document.