



Preterm

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

Assignment of payment (Credit Card)

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, _____, give my permission to Preterm to charge
Payer Name

\$ _____ to the below credit card, for provision of services to _____.
Patient Name

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.