

**POST STREET ORTHOPAEDICS &  
SPORTS MEDICINE, INC.**

2299 Post Street, Suite 107, San Francisco, CA 94115  
T: (415) 776-7878 | F: (415) 923-1036

**Leonard Gordon, MD**  
*Hand & Wrist Surgery*

**Thomas Sampson, MD**  
*Hip Arthroscopy*

**Elly LaRoque, MD**  
*Sports Medicine*

**Gary Salomon, MD, FACS**  
*Hand & Wrist Surgery*

**Kristin Wingfield, MD**  
*Sports Medicine*

**Catherine Cheung, DPM**  
*Foot & Ankle Surgery*

**Nicholas Colyvas, MD**  
*Shoulder & Knee*

**Connie Jardine, PA-C**  
*Physician's Assistant*

**ASSIGNMENT OF BENEFITS**

I hereby assign to Post Street Orthopaedics & Sports Medicine, Inc., 2299 Post Street, Suite 107, San Francisco, CA, all of my right, title, and interest in and to any and all health care and/or surgical benefits otherwise payable to me for medical treatment.

**FINANCIAL RESPONSIBILITY**

I acknowledge that I am still responsible for paying Post Street Orthopaedics & Sports Medicine, Inc. (PSOSM) to the extent that the relevant insurer, plan or payor does not pay PSOSM. I agree that I am responsible for paying PSOSM for the full amount of the charges for medical treatment provided by PSOSM.

I agree to immediately remit to PSOSM any and all payments subject to this assignment that I nonetheless receive directly from the relevant insurer, plan or payor. I understand that my failure to immediately remit such payments to PSOSM may cause PSOSM to incur collection costs and attorney's fees to collect such payments from me, and I agree that I shall be liable for PSOSM's collection costs and attorney's fees (plus interest on my outstanding balance at the rate of 10% per annum or the maximum amount allowed by law) if I receive payments subject to this assignment and do not immediately remit the payments to PSOSM.

**AUTHORIZATION TO RELEASE MEDICAL  
INFORMATION FOR PURPOSE OF BILLING**

I hereby authorize the release of medical information necessary to file a claim with my insurance carrier or other third party payor I agree to the assignment of benefits otherwise payable to me, PSOSM and my surgeon.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date