

## **ASSIGNMENT OF BENEFITS**

I hereby assign to Post Street Orthopaedics and 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 and Sports Medicine, Inc. to the extent that the relevant insurer, plan or payor does not pay Post Street Orthopaedics. I agree that I am responsible for paying Post Street Orthopaedics for the full amount of the charges for medical treatment provided by Post Street Orthopaedics and Sports Medicine, Inc.

I agree to immediately remit to Post Street Orthopaedics 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 Post Street Orthopaedics may cause Post Street Orthopaedics to incur collection costs and attorney's fees to collect such payments from me, and I agree that I shall be liable for Post Street Orthopaedics' collections 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 Post Street Orthopaedics.

## **AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR PURPOSES OF BILLING**

I hereby authorize the release of medical information necessary to file a claim with my insurance carrier or other third party payer I agree to the assignment of benefits otherwise payable to me, Post Street Orthopaedics and Sports medicine, and my surgeon.

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Patient Signature

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Date