

Estremera  
Franz

# OAK STREET MEDICAL, P.C.

1955 SOUTHERN BLVD 2<sup>ND</sup> FL, BRONX, NY 10460

TEL 7917-451-1447 FAX 7914-998-6226

## FRONTDESK SIGN IN SHEET

DATE: 01/08/26

DAY: Wednesday

#	PATIENT NAME	#	PATIENT NAME
1	Pulera Christian	26	
2	Rodriguez Amya	27	
3	Greene Akbar	28	
4	Lanki Lilian	29	
5	Dutheya Arias	30	
6	Elijah Reddick	31	<del>only [unclear]</del>
7	Rivas Santos	32	<del>[unclear]</del>
8	Garcia Nicol	33	
9	Bayoung Betayo	34	
10	Joselo Carden	35	
11	Michael Montgomer	36	<del>[unclear]</del>
12	Verity Balobus	37	
13	Flora Augusto Aguilar	38	
14	Houston Nyteeh	39	
15		40	
16		41	
17		42	
18		43	
19		44	
20		45	
21		46	
22		47	
23		48	
24		49	
25		50	

HAVE A BLESSED DAY!

**(01279)-RIVERA CHRISTIAN M**

Date of Birth - 7/16/2000 Sex - Male Marital Status - Single

Address: 2181 WALLACE AVE APT5D,The Bronx,NY,10462  
Phone #: (917) 402-9194

Social Security# - 066-90-4810

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 12/16/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : MVAIC

Address: 110 William Street

New York,NY,10038

Phone: 212-791-1280 Fax:

Claim# -

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - Bruce Newborough Firm Name - Bruce Newborough, PC

Attorney Address - 2104 Flatbush Avenue Brooklyn, NY 11234

Attorney Phone - 718-701-8826 Fax - 718-332-7334

Contact Person -

Other Insurance -

Medicare -

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NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

X Christian Rivera ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS. ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack  
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON  
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR  
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE  
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Christian Rivera  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

X 01/08/26  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301  
(Address of Provider)

01/08/26  
(Date of signature)

**DYNAMIC MOBILE XRAY SERVICES LLC**

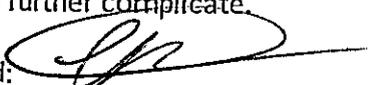
**3412 BLUESTONE LANE**

**EAST STROUDSBURG PA 18301**

**X-Ray Consent Form**

**Patient Consent To X-Ray:**

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 07/08/26

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_ who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 07/08/26

**Females: Regarding Possibility of Pregnancy**

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: \_\_\_\_\_ Date: 07/08/26

**(01278)-RODRIGUEZ AMYA C**

Date of Birth - 6/28/2003 Sex - Female Marital Status - Single

Address: 2181 WALLACE AVE APT 5D,The Bronx,NY,10462  
Phone #: (929) 444-0137

Social Security# - 113-92-5754

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 12/16/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : MVAIC

Address: 110 William Street

New York,NY,10038

Phone: 212-791-1280 Fax:

Claim# -

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - Bruce Newborough Firm Name - Bruce Newborough, PC

Attorney Address - 2104 Flatbush Avenue Brooklyn, NY 11234

Attorney Phone - 718-701-8826 Fax - 718-332-7334

Contact Person -

Other Insurance -

Medicare -

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NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

X Amiya Rodriguez, ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS., ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack  
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON  
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR  
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE  
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Amiya Rodriguez  
(Print name of Patient)

X Amiya Rodriguez  
(Signature of Patient)

X 01/08/26  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301  
(Address of Provider)

01/08/26  
(Date of signature)

**DYNAMIC MOBILE XRAY SERVICES LLC**

**3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301**

**X-Ray Consent Form**

**Patient Consent To X-Ray:**

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: Amaya Rodriguez Date: 07/08/26

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_ who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: \_\_\_\_\_ Date: 07/08/26

**Females: Regarding Possibility of Pregnancy**

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: Amaya Rodriguez Date: 07/08/26

**(01234)-GREENE AKBAR**

Date of Birth - 11/9/1971 Sex - Male Marital Status - Single

Address: 2475SOUTHERN 14 M,The Bronx,NY,10458  
Phone #: (443) 522-1218

Social Security# - 106-56-0241

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 11/17/2025  
Time/Place Accident -  
Date of Visit -  
Condition Related to : Auto Accident

Insurance Company : American Transit Insurance Co.  
Address: 275 7-Ave 2FL  
New York,NY,10001  
Phone: 800-683-2842 Fax: 2128578248

Claim# -  
Claim Address - 1 METRO TECH CENTER  
BROOKLYN NEW YORK 11201  
NF-2 - Yes Sending Date - 12/17/2025  
Policy Effective Date -  
Policy# - CAP608507  
Policy holder -  
WCB# -  
Carrier case # -

Attorney - RAYTSIN LAW FIRM, P.C. Firm Name - RAYTSIN LAW FIRM, P.C.  
Attorney Address - 221-10 JAMAICA AVE #106, QUEENS, NY 11428  
Attorney Phone - 718-355-9797 Fax - Contact Person -

Other Insurance -  
Medicare -

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NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

X Arbol Greene ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS. ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
to the contrary. (Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack  
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

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FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR  
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE  
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Arbol Greene  
(Print name of Patient)

X Arbol Greene  
(Signature of Patient)

\_\_\_\_\_  
(Address of Patient)

X 01/08/26  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

Arbol Greene  
(Signature of Provider)

3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301  
(Address of Provider)

01/08/26  
(Date of signature)

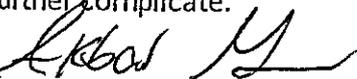
**DYNAMIC MOBILE XRAY SERVICES LLC**

**3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301**

**X-Ray Consent Form**

**Patient Consent To X-Ray:**

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 01/08/26

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_ who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: \_\_\_\_\_ Date: 01/08/26

**Females: Regarding Possibility of Pregnancy**

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: \_\_\_\_\_ Date: 01/08/26

**(01222)-LARKAI LILIAN**

Date of Birth - 8/30/1989    Sex - Female    Marital Status - Single

Address: 1591 FULTON AVE, The Bronx, NY, 10457  
Phone #: (609) 529-7487

Social Security# - XXX-XX-X

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 11/6/2025

Time/Place Accident - QUEENS HIGHWAY FROM BRONX TO THE JFK AIRPORT.

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : ACCIDENT FUND INSURANCE COMPANY

Address:

Phone:    Fax:

Claim# - 25000014876

Claim Address - 100 William St,  
New York, NY 10038

NF-2 - Yes    Sending Date - 12/05/2025

Policy Adjuster - ALYX

0 347 8987 EX 51991

Policy Effective Date -

Policy# - AU2025CAP10000-11

Policy holder -

WCB# -

Carrier case # -

Attorney - SURIS ACC    Firm Name - SURIS ASSOCIATES

Attorney Address -

Attorney Phone - 631-423-9700    Fax -                      Contact Person -

Other Insurance -

Medicare -

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NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

X I, Lilian Larkai, ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS., ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack  
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON  
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR  
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE  
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Lilian Larkai  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

X 01/08/26  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/08/26  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

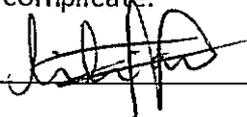
**DYNAMIC MOBILE XRAY SERVICES LLC**

**3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301**

**X-Ray Consent Form**

**Patient Consent To X-Ray:**

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 07/08/26

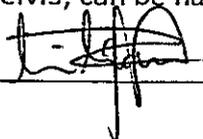
**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_ who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: \_\_\_\_\_ Date: 07/08/26

**Females: Regarding Possibility of Pregnancy**

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed:  Date: 07/08/26

**(01267)-ORTEGA DE ARIAS MIGUELINA**

Date of Birth - 8/11/1978 Sex - Female Marital Status - Married

Address: 1500 NOBLE AVE, The Bronx, NY, 10460  
Phone #: (347) 539-9141

Social Security# - 319-71-1203

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 11/19/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : American Transit Insurance Co.

Address: 275 7-Ave 2FL

New York, NY, 10001

Phone: 800-683-2842 Fax: 2128578248

Claim# -

Claim Address - 1 METRO TECH CENTER  
BROOKLYN NEW YORK 11201

NF-2 - Yes Sending Date - 12/16/2025

Policy Effective Date - 1/27/2025

Policy# - B906682

Policy holder - ARIAS, RAMON

WCB# -

Carrier case # -

Attorney - Bruce Newborough Firm Name - Bruce Newborough, PC

Attorney Address - 2104 Flatbush Avenue Brooklyn, NY 11234

Attorney Phone - 718-701-8826 Fax - 718-332-7334

Contact Person -

Other Insurance -

Medicare -

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NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

X M. Michelina Ortega ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS. ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
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PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X M. Michelina Ortega  
(Print name of Patient)

X MOR  
(Signature of Patient)

X 01/08/26  
(Date of signature)

1500 Noble NU Apto 100  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/08/26  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

**DYNAMIC MOBILE XRAY SERVICES LLC**

**3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301**

**X-Ray Consent Form**

**Patient Consent To X-Ray:**

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: Margelina Artega Date: 07/08/26

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_ who is a minor, \_\_\_\_\_ years of age: I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: \_\_\_\_\_ Date: 07/08/26

**Females: Regarding Possibility of Pregnancy**

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: [Signature] Date: 07/08/26

**(01231)-REDDICK ELIJAH M**

Date of Birth - 7/30/2004 Sex - Male Marital Status - Single

Address: 2310 BELMONT AVE, The Bronx, NY, 10458  
Phone #: (917) 499-4965

Social Security# - 074-94-0119

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 10/25/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone:      Fax:

Claim# - 88655888990000001

Claim Address - GEICO NY PIP

PO Box 9506

Fredericksburg, VA 22403-9506

NF-2 - Yes Sending Date - 11/26/2025

Policy Effective Date -

Policy# - 6218365960

Policy holder -

WCB# -

Carrier case # -

Attorney - Firm Name -

Attorney Address -

Attorney Phone - Fax -

Contact Person -

Other Insurance -

Medicare -

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NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

X Elijah Reddick, ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS., ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack  
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON  
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR  
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE  
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Elijah Reddick  
(Print name of Patient)

X E Reddick  
(Signature of Patient)

X 01/08/26  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301  
(Address of Provider)

01/08/26  
(Date of signature)

**DYNAMIC MOBILE XRAY SERVICES LLC**  
3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301

**X-Ray Consent Form**

**Patient Consent To X-Ray:**

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: E Reddick Date: 01/08/26

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_  
who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of  
said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I  
know of no other condition which the taking of x-rays would further complicate.

Signed: E Reddick Date: 01/08/26

**Females: Regarding Possibility of Pregnancy**

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has  
permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those  
involving the pelvis, can be hazardous to an unborn child.

Signed: E Reddick Date: 01/08/26



NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

X Robinson Rivas ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS. ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack  
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

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FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR  
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE  
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Robinson Rivas  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

X 01/08/26  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/08/26  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

**DYNAMIC MOBILE XRAY SERVICES LLC**

**3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301**

**X-Ray Consent Form**

**Patient Consent To X-Ray:**

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 07/08/26

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_ who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: \_\_\_\_\_ Date: 01/08/26

**Females: Regarding Possibility of Pregnancy**

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: \_\_\_\_\_ Date: 01/08/26

**(01286)-GARCIA NICOL U**

Date of Birth - 11/29/2002   Sex - Female   Marital Status - Single

Address: 2438 LYVERE ST, The Bronx, NY, 10461  
Phone #: (646) 455-7792

Social Security# - 112-92-002

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 12/21/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone:   Fax:

Claim# -

Claim Address - GEICO NY PIP  
PO Box 9506  
Fredericksburg, VA 22403-9506

Policy Effective Date -

Policy# - 619169933

Policy holder - RODRIGUEZ, RODRIGUEZ

WCB# -

Carrier case # -

Attorney - Firm Name -

Attorney Address -

Attorney Phone - Fax -

Contact Person -

Other Insurance -

Medicare -

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

X Nicol Garavito, ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS., ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack  
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON  
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR  
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE  
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Nicol G  
(Print name of Patient)

X Nicol G  
(Signature of Patient)

X 01/08/26  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/08/26  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

**DYNAMIC MOBILE XRAY SERVICES LLC**  
3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301

**X-Ray Consent Form**

**Patient Consent To X-Ray:**

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: Nicol G Date: 01/08/26

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_  
who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of  
said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I  
know of no other condition which the taking of x-rays would further complicate.

Signed: Nicol G Date: 01/08/26

**Females: Regarding Possibility of Pregnancy**

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has  
permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those  
involving the pelvis, can be hazardous to an unborn child.

Signed: Nicol G Date: 01/08/26

**(01239)-BANGOURA BEKAYE**

Date of Birth - 3/9/1964 Sex - Male Marital Status - Single

Address: 520 ROSEDALE AVE APT E52, The Bronx, NY, 10473  
Phone #: (917) 736-1101

Social Security# - 122-82-8988

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 10/25/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 8696039790000003

Claim Address - GEICO NY PIP

PO Box 9506

Fredericksburg, VA 22403-9506

NF-2 - Yes Sending Date - 11/26/2025

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - MORGAN & MORGAN

Attorney Address -

Attorney Phone - Fax -

Firm Name - MORGAN & MORGAN

Contact Person -

Other Insurance -

Medicare -

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

I, Bangoura Betayee, ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS., ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack  
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON  
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR  
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE  
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Bangoura Betayee [Signature]  
(Print name of Patient) (Signature of Patient)

01/08/26  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/08/26  
(Date of signature)

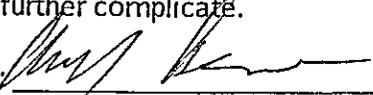
EAST STROUDSBURG PA 18301  
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC  
3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301

X-Ray Consent Form

Patient Consent To X-Ray:

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 01/08/26

Consent To X-Ray:

A Minor I am a parent or legal guardian of \_\_\_\_\_ who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: \_\_\_\_\_ Date: 01/08/26

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: \_\_\_\_\_ Date: 01/08/26

**(01283)-TRONCOSO CARMEN Y**

Date of Birth - 04/11/1978 Sex - Male Marital Status - Single

Address: 85 HOOKER RD,BRIDGEPORT,CT,06610  
Phone #: (646) 750-9991

Social Security# - 125-84-1863

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 12/16/2025

Time/Place Accident - RYE BROOK VILLAGE OF -6043 HUTCHINSON RIVER PKWY

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : State Farm Insurance Company

Address:

Phone: 9733057000 Fax:

Claim# -

Claim Address - P.O. BOX 106170  
ATLANTA G.A. 30348-6170

Policy Effective Date -

Policy# - 114 5499-B29-07B

Policy holder - TRONCOSO,CARMEN Y , & FIGUEROA CASTRO , ISRAEL

WCB# -

Carrier case # -

Attorney - RAYTSIN LAW FIRM Firm Name - RAYTSIN LAW FIRM

Attorney Address -

Attorney Phone - 718-355-9797 Fax - 718-223-5953

Contact Person -

Other Insurance -

Medicare -

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NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

X Carmen Troncoso, ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS., ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack  
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR OTHER PERSON  
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR  
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE  
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Carmen Troncoso  
(Print name of Patient)

X Carmen Troncoso  
(Signature of Patient)

X 01/08/26  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/08/26  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC  
3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301

X-Ray Consent Form

Patient Consent To X-Ray:

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: *Grant Hornow* Date: 01/08/26

Consent To X-Ray:

A Minor I am a parent or legal guardian of \_\_\_\_\_, who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: \_\_\_\_\_ Date: 01/08/26

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: *Grant Hornow* Date: 01/08/26

**(01312)-MONTGOMERY MICHAEL A**

Date of Birth - 04/09/1980 Sex - Male Marital Status - Single

Address: 1420 WASHINGTON AVE,The Bronx,NY,10456  
Phone #: (347) 854-9502

Social Security# - 086-64-5176

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 01/07/2026

Time/Place Accident - BRUCKNER EXPWY NEAR EXIT 54

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : NEW YORK AUTOMOIBLE

Address:

Phone: Fax:

Claim# -

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - Firm Name -

Attorney Address -

Attorney Phone - Fax -

Contact Person -

Other Insurance -

Medicare -

---

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

X Michael Montgomery ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS. ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack  
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON  
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR  
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE  
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Michael Montgomery  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

X 01/08/26  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/08/26  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC  
3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301

X-Ray Consent Form

Patient Consent To X-Ray:

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: Michael Mota Date: 07/08/26

Consent To X-Ray:

A Minor I am a parent or legal guardian of \_\_\_\_\_ who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: Michael Mota Date: 01/08/26

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: Michael Mota Date: 01/08/26

01/08/2026

**(01273)-BALGOBIN DESTINY J**

Date of Birth - 02/22/1994 Sex - Female Marital Status - Single

Address: 2075 2ND AVE APT 11E,The Bronx,NY,10029  
Phone #: (646) 573-1203

Social Security# - XXX-XX-XXXX

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 12/05/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : CURE AUTO INSURANCE

Address:

Phone: Fax:

Claim# - PANJ185573

Claim Address - 214 CARNEGIE CENTER DRIVE  
PRINCETON NEW JERSEY 08540

NF-2 - Yes

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

To Attorney - Bruce Newborough Firm Name - Bruce Newborough, PC

Attorney Address - 2104 Flatbush Avenue Brooklyn, NY 11234

Attorney Phone - 718-701-8826 Fax - 718-332-7334

Contact Person -

Other Insurance -

Medicare -

---

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

X Destiny Babylon ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS. ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on 01/15/25, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack  
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON  
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR  
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE  
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Destiny Babylon  
(Print name of Patient)

X Destiny Babylon  
(Signature of Patient)

X 01/08/26  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/08/26  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC  
3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301

X-Ray Consent Form

Patient Consent To X-Ray:

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: Destiny Beal Date: 07/08/26

Consent To X-Ray:

A Minor I am a parent or legal guardian of \_\_\_\_\_ who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: Destiny Beal Date: 07/08/26

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: Destiny Beal Date: 07/08/26

**(01284)-FLORES AGUILAR AUGUSTO**

Date of Birth - 05/05/1958 Sex - Male Marital Status - Single

Address: 1517 OVERING ST,The Bronx,NY,10461  
Phone #: (917) 394-1519

Social Security# - XXX-XX-XX

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 12/18/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : MTA

Address:

Phone: Fax:

Claim# -

Claim Address - 130 LIVINGSTONE STREET  
10TH FL BROOKLYN, NY 11201

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - Bruce Newborough Firm Name - Bruce Newborough, PC

Attorney Address - 2104 Flatbush Avenue Brooklyn, NY 11234

Attorney Phone - 718-701-8826 Fax - 718-332-7334

Contact Person -

Other Insurance -

Medicare -

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NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

X Augusto Flores ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS. ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack  
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON  
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR  
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE  
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Augusto Flores  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

X 01/08/26  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/08/26  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

**DYNAMIC MOBILE XRAY SERVICES LLC**  
**3412 BLUESTONE LANE**  
**EAST STROUDSBURG PA 18301**

**X-Ray Consent Form**

**Patient Consent To X-Ray:**

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: Augusto Flores Date: 07/08/26

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_  
who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: Augusto Flores Date: 01/08/26

**Females: Regarding Possibility of Pregnancy**

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: Augusto Flores Date: 01/08/26

**(01257)-HOUSTON NYJEEH**

Date of Birth - 12/12/1997 Sex - Male Marital Status - Single

Address: 259 E 182 ST,The Bronx,NY,10457  
Phone #: (929) 490-8801

Social Security# - XXX-XX-9414

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 11/30/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : Integon National Insurance Co.

Address: P.O.Box 22086

Burlington,NJ,27215

Phone: 518--431-6410 Fax:

Claim# - 260019001

Claim Address - P.O BOX 1623

WINSTON-SALEM.NC 27102

NF-2 - Yes Sending Date - 12/30/2025

Policy Effective Date -

Policy# - 64731220

Policy holder -

WCB# -

Carrier case # -

To Attorney - KANDKHOROV & ASSOCIATES PLLC Firm Name - KANDKHOROV & ASSOCIATES PLLC

Attorney Address - 215-15 NORTHERN BOULEVARD 3RD FL BAYSIDE, NY 11361

Attorney Phone - 212-888-8899 Fax - Contact Person -

Other Insurance -

Medicare -

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NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: \_\_\_\_\_

X Nybeeh Houston, ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS., ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I am  
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement  
(Print accident date)  
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack  
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON  
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR  
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE  
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,  
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,  
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR  
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR  
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND  
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF  
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Nybeeh Houston  
(Print name of Patient)

X Nybeeh Houston  
(Signature of Patient)

259 E 182 Street, Bronx, NY  
(Address of Patient)

01/08/26  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/08/26  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

**DYNAMIC MOBILE XRAY SERVICES LLC**  
**3412 BLUESTONE LANE**  
**EAST STROUDSBURG PA 18301**

**X-Ray Consent Form**

**Patient Consent To X-Ray:**

I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: *Walter H.* Date: 01/08/26

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_  
who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of  
said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time I  
know of no other condition which the taking of x-rays would further complicate.

Signed: \_\_\_\_\_ Date: 01/08/26

**Females: Regarding Possibility of Pregnancy**

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has  
permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those  
involving the pelvis, can be hazardous to an unborn child.

Signed: \_\_\_\_\_ Date: 01/08/26