

~~2425~~ Eastchester Alamo

### Patient Sign-In

Date: 01/12/26

Please sign-in and notify us if:

- New Patient
- Phone/address change
- Insurance Change

NO.	Patient Name Please Print	Appt. Time	Arrival Time	Appt. with	New Patient (✓)	Phone/address Change (✓)	Insurance Change (✓)
1	1 Wise Sean						
2	2 Campbell Brianna						
3	3 Virginia pellev						
4	4 Constantes Hernandez						
5	5 Camacho Tamara						
6	6 Apata IBILOLA						
*7	7 Rawling Dale						NO EXTREMITY
8	8 Maurel Bennet						
9	9 Jara JOANNY						
10	10 Marshal Harris						
11	11 Daley Jhanille						
12	12 Rivera Andrew						
13	13 Sookra neel						
14	14 Cardenas joselyn						
15	15						
16	16						
17	17						
18	18						
19	19						
20	20						
21	21						
22	22						
23	23						
24	24						
25	25						

1/12/2026

**(01140)-Cardenas Joselyn**

Date of Birth - 11/15/1987 Sex - Female Marital Status - Single

Address: 830 Magenta Street #2C, Bronx, NY, 10467  
Phone #: (347) 873-3536

Social Security# - - -0317

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 10/16/2025

Time/Place Accident - Bruckner / Hunts Point

Policy Report - Yes

Date of Visit - 10/22/2025

Condition Related to : Auto Accident

Insurance Company : State Farm Mutual Automobile Insurance Co.

Address: P.O. Box 106170

Atlanta, GA, 30348-6170

Phone: 800-258-9884 Fax:

Claim# - 52-91R6-34X

NF-2 - Yes Sending Date - 10/29/2025

Policy Adjuster - Toni Helms

Policy Effective Date -

Policy# - 369 3145-C05-52

Policy holder - Cardenas-Matias, Joselyn, S

WCB# -

Carrier case # -

Attorney - Adam Oremland, ESQ. Firm Name - Oremland Law Group PC

Attorney Address - 2426 Eastchester Rd, Suite 203, Bronx, NY. 10469

Attorney Phone - 718-367-1700 Fax - 718-367-1701

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 Joselyn Cardenas, ("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 10/16/25, 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 Joselyn Cardenas  
(Print name of Patient)

X Joselyn Cardenas  
(Signature of Patient)

X 01/02/06  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/12/06  
(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: \_\_\_\_\_

*Joelynn Barber*

Date: \_\_\_\_\_

*01/12/06*

**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: \_\_\_\_\_

*01/12/06*

**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: \_\_\_\_\_

*Joelynn Barber*

Date: \_\_\_\_\_

*01/12/06*

1/12/2026

**(01156)-Sookra Neel**

Date of Birth - 9/7/1989    Sex - Male    Marital Status - Single

Address: 220 Saint Johns Avenue, Yonkers, NY, 10704  
Phone #: (914) 507-2755

Social Security# - - -0056

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 12/16/2025

Time/Place Accident -

Date of Visit - 12/31/2025

Condition Related to : Auto Accident

Insurance Company : GEICO Indemnity Co.

Address: Geico NY PIP P.O. Box 9507

Fredericksburg , VA, 22403

Phone: (516) 496-5214    Fax: (856) 294-5154

Claim# - 8875118780000001

Policy Effective Date -

Policy# -

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 NEEL SODERA, ("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 16/12/25, 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 DEFAUD 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 NEEL SODERA  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

220 Saint Johns Avenue Yonkers  
(Address of Patient)

X 01/02/06  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/12/06  
(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: Neel Sodra Date: 01/12/06

**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: Neel Sodra Date: 01/12/06

**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: Neel Sodra Date: 01/12/06

1/12/2026

**(01157)-Rivera Andrew**

Date of Birth - 3/31/1988    Sex - Male    Marital Status - Single

Address: 4728 Bronx Blvd #1, Bronx, NY, 10470  
Phone #: (347) 899-5512

Social Security# - - -2746

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 12/16/2025

Time/Place Accident -

Date of Visit - 12/31/2025

Condition Related to : Auto Accident

Insurance Company : GEICO Indemnity Co.

Address: Geico NY PIP P.O. Box 9507

Fredericksburg , VA, 22403

Phone: (516) 496-5214    Fax: (856) 294-5154

Claim# - 887118780000001

Policy Effective Date -

Policy# -

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 Andrew 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 Andrew Rivera  
(Print name of Patient)

X AR  
(Signature of Patient)

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

X 01/02/06  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/12/06  
(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: AR Date: 01/12/06

**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: 01/12/06

**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: 01/12/06

1/12/2026

**(01147)-Daley Jhanielle**

Date of Birth - 3/19/1993 Sex - Female Marital Status - Single

Address: 488 Warburton Ave #3, Yonkers, NY, 10701  
Phone #: (914) 513-1840

Social Security# - - -8098

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 10/17/2025

Time/Place Accident - Boston Rd / Conner Street

Policy Report - Yes

Date of Visit - 11/17/2025

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 8832684550000003

NF-2 - Yes Sending Date - 11/17/2025

Policy Effective Date -

Policy# - 4300951029

Policy holder - Daley, Jhanielle, C

WCB# -

Carrier case # -

Attorney - Klafter Law Group Firm Name - Klafter Law Group

Attorney Address - 36-36 33rd Street, Suite 307, Long Island City, NY. 11106

Attorney Phone - 718-465-1160 Fax - 646-273-2500

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, Jhavielle Daley, ("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 10/17/2025, 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 Jhavielle Daley  
(Print name of Patient)

X JMD  
(Signature of Patient)

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

X 01/02/06  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/12/06  
(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**

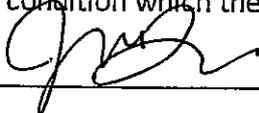
**Patient Consent To X-Ray:**

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: 01/12/06

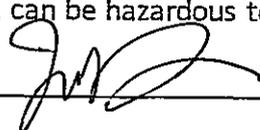
**Consent To X-Ray:**

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: 01/12/06

**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: 01/12/06

**(01149)-Marshall-Harris Janet**

Date of Birth - 11/6/1962 Sex - Female Marital Status - Married

Address: 248 Summit Ave 2nd floor, Mount Vernon, NY, 10552  
Phone #: (347) 583-3888

Social Security# - - -4330

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 11/18/2025  
Time/Place Accident -  
Date of Visit - 11/19/2025  
Condition Related to : Auto Accident

Insurance Company : New York Municipal Ins. Reciprocal  
Address: 900 Stewart Ave, Ste 600  
Garden City, NY, 11530  
Phone: 800-345-0311 Fax:

Claim# - WEST20251720001  
Claim Address - New York Municipal Ins. Reciprocal  
c/o Wright Risk Management  
900 Stewart Ave, Suite 600  
Garden City, NY. 11530

NF-2 - Yes Sending Date - 12/03/2025

Policy Adjuster - Terry Barrett

(518)-292-0064 F:516-222-5392

Policy Effective Date -

Policy# - MCA-WEST-0000003-25

Policy holder - Westchester County

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 Janet M Harris ("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 Janet Marshall Harris  
(Print name of Patient)

X Janet Marshall Harris  
(Signature of Patient)

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

X 01/02/06  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/12/06  
(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: Janet Marshall-Harris Date: 01/12/06

**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: 01/12/06

**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: Janet Marshall-Harris Date: 01/12/06

1/12/2026

**(01130)-Jara Joanna**

Date of Birth - 8/18/1988 Sex - Female Marital Status - Married

Address: 647 East 219th Street #1FL,Bronx,NY,10467

Phone #: (917) 355-9308

Social Security# - - -1314

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 8/30/2025

Time/Place Accident -

Policy Report - Yes

Date of Visit - 9/3/2025

Condition Related to : Auto Accident

Insurance Company : Government Employees Insurance Co.

Address:

Phone: Fax:

Claim# - 0619029490101031

NF-2 - Yes Sending Date - 09/16/2025

Policy Effective Date -

Policy# - 4526800570

Policy holder - Miguel Jara

WCB# -

Carrier case # -

Attorney - Oremland Law Group PC Firm Name - Oremland Law Group PC

Attorney Address - 2426 Eastchester Rd, Suite 203, Bronx, NY. 10469

Attorney Phone - 718-367-1700 Fax - 718-367-1701

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 Joanna Tarc ("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 08/20/05, 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 Joanna Tarc  
(Print name of Patient)  
647 East 29 St.  
Brooklyn 10467  
(Address of Patient)

X [Signature]  
(Signature of Patient)  
X 01/02/06  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)  
01/12/06  
(Date of signature)

3412 BLUESTONE LANE  
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: 01/12/06

**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: 01/12/06

**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: 01/12/06

1/12/2026

**(01131)-Maurer Bennet J.**

Date of Birth - 4/20/1968 Sex - Male Marital Status - Single

Address: 130 East 177th St, Bronx, NY, 10463

Phone #: (917) 995-1736

Social Security# - - -9407

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 8/25/2025

Time/Place Accident - 8th Street / Jacob Street (Troy)

Policy Report - Yes

Date of Visit - 9/2/2025

Condition Related to : Auto Accident

Insurance Company : Progressive Casualty Insurance Company

Address: PO Box 22031

Albany, NY, 12201

Phone: Fax:

Claim# - 25-263963475

NF-2 - Yes Sending Date - 09/16/2025

Policy Effective Date -

Policy# -

Policy holder - Weisberg, Dominick J

WCB# -

Carrier case # -

Attorney - Oremland Law Group PC Firm Name - Oremland Law Group PC

Attorney Address - 2426 Eastchester Rd Suite 203, Bronx, NY. 10469

Attorney Phone - 718-367-1700 Fax - 718-367-1701

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 Bennet Maurer ("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 Aug 26, 2006, 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.

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 Bennet Maurer  
(Print name of Patient)

X Bennet J  
(Signature of Patient)

130 f  
(Address of Patient)

X 01/02/06  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/12/06  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

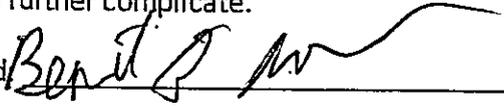
**DYNAMIC MOBILE XRAY SERVICES LLC**

**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: 01/12/06

**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: 01/12/06

**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: 01/12/06

1/12/2026

**(01154)-Rawlings Dale**

Date of Birth - 4/23/1974    Sex - Male    Marital Status - Single

Address: 2769 Matthews Avenue #6D, Bronx, NY, 10467  
Phone #: (917) 853-5939

Social Security# - - -0998

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 12/29/2025

Time/Place Accident - Cruge Avenue / Boston Road

Policy Report - Yes

Date of Visit - 12/30/2025

Condition Related to : Auto Accident

Insurance Company : Allstate Fire And Casualty Insurance Company

Address: PO BOX 2874

Clinton ,IA,52733-2874

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 -

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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 Dale Rawlings ("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 Dale Rawlings  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

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

X 01/02/06  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

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

01/12/06  
(Date of signature)

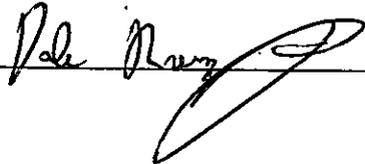
**DYNAMIC MOBILE XRAY SERVICES LLC**

**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: 01/12/06

**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: 01/12/06

**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: 01/12/06

1/12/2026

**(01139)-Apata Ibilola**

Date of Birth - 11/9/1966 Sex - Female Marital Status - Single

Address: 915 Burke Avenue, Bronx, NY, 10469

Phone #: (347) 549-2673

Social Security# - - -7185

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 10/10/2025

Time/Place Accident -

Date of Visit - 10/20/2025

Condition Related to : Auto Accident

Insurance Company : Progressive Advanced Insurance Company

Address:

Phone: Fax:

Claim# - 25-216067660

NF-2 - Yes Sending Date - 10/30/2025

Policy Effective Date -

Policy# -

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 I, Ibilola Apata, ("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 Ibilola Apata  
(Print name of Patient)

X Ibilola Apata  
(Signature of Patient)

915 Burke Ave, Bronx NY  
(Address of Patient)

X 01/02/06  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/12/06  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)



1/12/2026

**(01153)-Cammack Tamara G.**

Date of Birth - 12/7/1965 Sex - Female Marital Status - Single

Address: 1550 Townsend Avenue #3D, Bronx, NY, 10452  
Phone #: (917) 379-7102

Social Security# - - -8921

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 12/18/2025

Time/Place Accident -

Policy Report - Yes

Date of Visit - 12/24/2025

Condition Related to : Auto Accident

Insurance Company : Progressive Advanced Insurance Company

Address:

Phone: Fax:

Claim# - 25-519524341

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - Adam Oremland, ESQ. Firm Name - Oremland Law Group PC

Attorney Address - 2426 Eastchester Rd, Suite 203, Bronx, NY. 10469

Attorney Phone - 718-367-1700 Fax - 718-367-1701

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 Tamara Lammek ("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 Tamara Lammek  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

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

X 01/02/06  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

01/12/06  
(Date of signature)

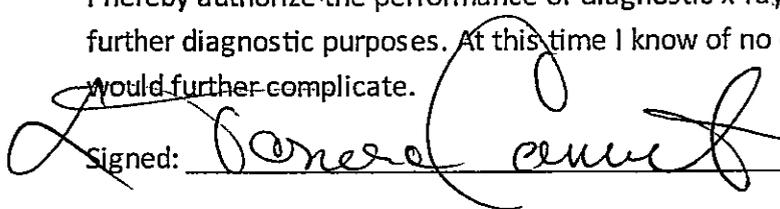
EAST STROUDSBURG PA 18301  
(Address of Provider)

**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: 1/12/20

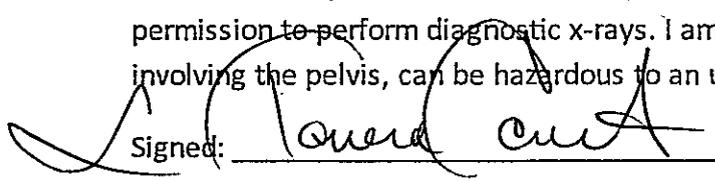
**Consent To X-Ray:**

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: \_\_\_\_\_

**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: 1/12/20

1/12/2026

**(01121)-Cervantes Hernandez Elizabeth**

Date of Birth - 2/11/1988 Sex - Female Marital Status - Single

Address: 1954 Gleason Avenue #1B, Bronx, NY, 10472  
Phone #: (347) 495-7296

Social Security# - - -7181

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 8/11/2025

Time/Place Accident - Pelham Parkway South Entrance / Adjacent BLDG 8

Policy Report - Yes

Date of Visit - 8/18/2025

Condition Related to : Auto Accident

Insurance Company : Progressive Casualty Insurance Company

Address: PO Box 22031

Albany, NY, 12201

Phone: Fax:

Claim# - 25-886789667

NF-2 - Yes Sending Date - 09/04/2025

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - Klafter Law Group Firm Name - Klafter Law Group

Attorney Address - 36-36 33rd Street, Suite 307, Long Island City, NY. 11106

Attorney Phone - 718-465-1160 Fax - 646-273-2500

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 Elizabeth Cervantes, ("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 Elizabeth Cervantes  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

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

X 01/02/06  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

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

01/12/06  
(Date of signature)

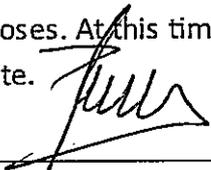
**DYNAMIC MOBILE XRAY SERVICES LLC**  
**3412 BLUESTONE LANE**  
**EAST STROUDSBURG PA 18301**

**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: \_\_\_\_\_

01/12/2026

**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: \_\_\_\_\_

**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: \_\_\_\_\_

01/12/2026

1/12/2026

**(01141)-Pellecier Virginia**

Date of Birth - 10/6/1967    Sex - Female    Marital Status - Married

Address: 3422 Knox Place #4B, Bronx, NY, 10467  
Phone #: (347) 754-1276

Social Security# - - -5914

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 10/4/2025

Time/Place Accident -

Date of Visit - 10/23/2025

Condition Related to : Auto Accident

Insurance Company : State Farm Mutual Automobile Insurance Co.

Address: P.O. Box 106170

Atlanta, GA, 30348-6170

Phone: 800-258-9884    Fax:

Claim# - 32-91F3-263

NF-2 - No

Policy Effective Date -

Policy# -

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 Virginia Pellecier, ("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 Virginia Pellecier  
(Print name of Patient)

X Virginia Pellecier  
(Signature of Patient)

X 01/02/06  
(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)

01/12/06  
(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: Virginia Pellicci Date: 1/12/26

**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: \_\_\_\_\_

**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: Virginia Pellicci Date: 1/12/26

1/12/2026

**(01152)-Campbell Brianna**

Date of Birth - 2/18/1999    Sex - Female    Marital Status - Single

Address: 141 S. Prince Street, Lancaster, NY, 17603  
Phone #: (917) 794-5755

Social Security# - - -

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 12/22/2025  
Time/Place Accident - W 164th Street / Woodycrest Avenue  
Policy Report - Yes  
Date of Visit - 12/23/2025  
Condition Related to : Auto Accident

Insurance Company : Hugo Insurance  
Address:

Phone:    Fax:

Claim# - 0372506611

Policy Adjuster -

800-468-3466

Policy Effective Date -

Policy# - HUGO-3831500

Policy holder - Brianna Campbell

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 Brianna Campbell ("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.

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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 Brianna Campbell  
(Print name of Patient)  
1219 E 224<sup>th</sup> st  
Bron  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)  
3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301  
(Address of Provider)

X B. Camp  
(Signature of Patient)  
X 01/02/06  
(Date of signature)

[Signature]  
(Signature of Provider)  
01/12/06  
(Date of signature)

**DYNAMIC MOBILE XRAY SERVICES LLC**

**3412 BLUESTONE LANE**

**EAST STROUDSBURG PA 18301**

**X-Ray Consent Form**

**Patient Consent To X-Ray:**

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Signed: B. Camp Date: 1/12/20

**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: B. Camp Date: 1/12/20

**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: B. Camp Date: 1/12/20

1/12/2026

**(01142)-Wise Sean C.**

Date of Birth - 5/2/1974 Sex - Male Marital Status - Single

Address: 3784 10th Avenue, New York, NY, 10034  
Phone #: (347) 329-7340

Social Security# - - -3502

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 10/18/2025  
Time/Place Accident - Lexington Avenue / East 129th Street  
Policy Report - Yes  
Date of Visit - 10/30/2025  
Condition Related to : Auto Accident

Insurance Company : State Farm Mutual Automobile Insurance Co.  
Address: P.O. Box 106170  
Atlanta, GA, 30348-6170  
Phone: 800-258-9884 Fax:

Claim# - 5292V681M  
NF-2 - Yes Sending Date - 11/13/2025  
Policy Effective Date -  
Policy# - 352 9661-D20-52C  
Policy holder - Rosa Eva  
WCB# -  
Carrier case # -

Attorney - Adam Oremland, ESQ. Firm Name - Oremland Law Group PC  
Attorney Address - 2426 Eastchester Rd, Suite 203, Bronx, NY. 10469  
Attorney Phone - 718-367-1700 Fax - 718-367-1701  
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 Sean Wise, ("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.

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THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Sean Wise  
(Print name of Patient)

X Sean Wise  
(Signature of Patient)

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

X 01/02/06  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

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

01/12/06  
(Date of signature)

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Signed: Sean Wise Date: 1/12/26

**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: \_\_\_\_\_

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