

OAK STREET MEDICAL, P.C.

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

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

FRONTDESK SIGN IN SHEET

E. L. J. J.

DATE: 01/22/26

DAY: Thursday

#	PATIENT NAME	#	PATIENT NAME
1	Dominique Corley	26	
2	Arturo Gonzalez Lulo	27	
3	Rodriguez Luis David	28	
4	Agosto Williams	29	
5	Jagan Jenera	30	
6	Jamou Rosano	31	
7	Wilfredo Ramos	32	
8	Vilma Gonzalez	33	
9	Jennifer Ortiz	34	
10	Michelle Caraballo	35	
11	Baez Meghell	36	
12	Esgare Vasquez	37	
13	Cepeda name	38	
14	Mimi Leonardo	39	
15	Rutho Pablo	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!

(01321)-BRITO PABLO

Date of Birth - 12/26/1997 Sex - Male Marital Status - Single

Address: 1231 SHERIDAN AVE #27, The Bronx, NY, 10456
Phone #: (347) 490-0014

Social Security# -

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 1/13/2026

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: 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 -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Brito, pablo
 Date of Birth: 12/26/1997
 Date of Accident: 01/13/2026
 Date of Service: 01/20/2026

The patient states that he/she was in a MVA/WC related accident and was a driver passenger (front/rear)
 After the accident he went to X hospital / Urgent
 Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 28 years-old male / female who presented in my office with following complaints:
 Neck pain.
 Upper / Lower back pain.
 Shoulders pain (Right / Left / Both)
 Knee pain (Right / Left / Both)
 Elbow pain (Right / Left / Both)
 Ankle pain (Right / Left / Both)
 Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine
 Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.
 Thorax : No deformities were noted.
 Eyes: Pupils were round, regular and equal. They reacted normally to light.
Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance -Good, Patient is cooperative. Height: 5-6", Weight: 230 Lbs.,
 HEENT: Normal
 Abdomen: No complaints of masses, tenderness or rigidity and noted.
 Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, Pablo Brito, ("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.

Pablo Brito
(Print name of Patient)

Pablo Brito
(Signature of Patient)

01/22/26
(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)

01/22/26
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301
Tel: (570) 243-1888

X-Ray Consent Form

Parent 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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: Paul Brits Date: 01/22/26

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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: Paul Brits Date: 01/22/26

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: Paul Brits Date: 01/22/26

(01322)-LEONARDO MIKI

Date of Birth - 5/26/1977 Sex - Male Marital Status - Single

Address: 1231 SHERIDAN AVE #29, The Bronx, NY, 10456
Phone #: (646) 575-6682

Social Security# - 088-82-8972

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 1/13/2026

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: 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 -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Leonardo, Miki

Date of Birth: 05/26/1977

Date of Accident: 01/13/2026

Date of Service: 01/20/2026

The patient states that he/she was in a MVA / WC related accident and was a driver / passenger (front/rear)

After the accident he went to X hospital / Urgent

Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 48 years-old male / female who presented in my office with following complaints:

- Neck pain.
- Upper / Lower back pain.
- Shoulders pain (Right / Left / Both)
- Knee pain (Right / Left / Both)
- Elbow pain (Right / Left / Both)
- Ankle pain (Right / Left / Both)
- Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine

Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.

Thorax : No deformities were noted.

Eyes: Pupils were round, regular and equal. They reacted normally to light.

Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance - Good, Patient is cooperative. Height: 4-11", Weight: 130 Lbs.,

HEENT: Normal

Abdomen: No complaints of masses, tenderness or rigidity and noted.

Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, _____, ("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.

Miki Leonardo
(Print name of Patient)

Mike Leonardo
(Signature of Patient)

01/22/26
(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)

01/22/26
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301
Tel: (570) 243-1888

X-Ray Consent Form

Parent 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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: M. M. Leonardo Date: 01/22/26

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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: M. M. Leonardo Date: 01/22/26

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: M. M. Leonardo Date: 01/22/26

(01328)-CEPEDA MARIA

Date of Birth - 7/29/1980 Sex - Male Marital Status - Single

Address: 450 W 163RD ST APT1B,New York,NY,10032
Phone #: (917) 891-0288

Social Security# - 066-80-2870

Employer or Company Name:

Address:
Emergency Name:
Work Phone #:

Date of Accident - 12/19/2025
Time/Place Accident -
Date of Visit -
Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.
Address:

Phone: Fax:

Claim# - 8808435450000001
Claim Address - GEICO NY PIP
P.O BOX 9506
FREDERICKSBURG,VA 22403-9506

NF-2 - Yes Sending Date - 01/20/2026
Policy Effective Date -
Policy# -
Policy holder -
WCB# -
Carrier case # -

To 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 -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Cepeda, Maria
 Date of Birth: 07/29/1980
 Date of Accident: 12/19/2025
 Date of Service: 01/15/2026

The patient states that he/she was in a MVA / WC related accident and was a driver / passenger (front/rear)
 After the accident he went to X hospital / Urgent
 Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 45 years-old- male / female who presented in my office with following complaints:

- Neck pain.
- Upper / Lower back pain.
- Shoulders pain (Right / Left / Both)
- Knee pain (Right / Left / Both)
- Elbow pain (Right / Left / Both)
- Ankle pain (Right / Left / Both)
- Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine
 Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.
 Thorax : No deformities were noted.
 Eyes: Pupils were round, regular and equal. They reacted normally to light.
 Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance -Good, Patient is cooperative. Height: 5-8", Weight: 315 Lbs.,
 HEENT: Normal
 Abdomen: No complaints of masses, tenderness or rigidity and noted.
 Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, Mana Capete ("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 12-19-2025, 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.

Mana Capete
(Print name of Patient)

[Signature]
(Signature of Patient)

250 ALST 163 Apt 1B

01/22/26
(Date of signature)

New York, NY 10032
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

01/22/26
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

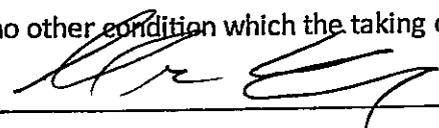
Parent Consent To X-Ray:

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

Signed:  Date: 01/22/26

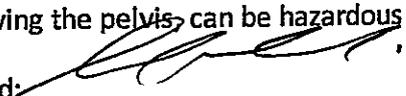
Consent To X-Ray:

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 point I
know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 01/22/26

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: 01/22/26

(01305)-EALEY DOMINIQUE K

Date of Birth - 6/8/1996 Sex - Female Marital Status - Single

Address: 1290 RODMAN PLACE, The Bronx, NY, 10460
Phone #: (347) 408-5912

Social Security# - 061-86-9389

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 : MVAIC

Address: 110 William Street

New York, NY, 10038

Phone: 212-791-1280 Fax:

Claim# -

Claim Address - 100 William St,

New York, NY 10038

NF-2 - Yes Sending Date - 01/21/2026

Policy Effective Date -

Policy# -

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 -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Faley, Dominique
 Date of Birth: 06/08/1996
 Date of Accident: 12/21/2025
 Date of Service: 01/06/2026

The patient states that he/she was in a MVA / WC related accident and was a driver / ~~passenger~~ (front/rear)
 After the accident he went to Montefiore hospital / Urgent
 Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 29 years-old- male / female who presented in my office with following complaints:

- Neck pain.
- Upper / Lower back pain.
- Shoulders pain (Right) / Left / Both)
- Knee pain (Right / Left / Both)
- Elbow pain (Right / Left / Both)
- Ankle pain (Right / Left / Both)
- Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine
 Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.
 Thorax : No deformities were noted.
 Eyes: Pupils were round, regular and equal. They reacted normally to light. Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance -Good, Patient is cooperative. Height: 5-4", Weight: 140 Lbs., HEENT: Normal

Abdomen: No complaints of masses, tenderness or rigidity and noted.

Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, Dominique Ealey ("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.

Dominique Ealey
(Print name of Patient)

D. Ealey
(Signature of Patient)

01/22/26
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

01/22/26
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

Parent 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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: D. Ealey Date: 01/22/26

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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: D. Ealey Date: 01/22/26

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: D. Ealey Date: 01/22/26

(01323)-LUCIO GONZALEZ ARTURO

Date of Birth - 5/10/1980 Sex - Male Marital Status - Single

Address: 2294 BELMONT AVE,The Bronx,NY,10457
Phone #: (347) 858-3942

Social Security# - XXX-XX-XXX

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 1/15/2026

Time/Place Accident -

Date of Visit -

Insurance Company : Esurance Property and Casualty Insurance Company

Address:

Phone: Fax:

Claim# -

Policy Effective Date -

Policy# - PANY-009276685

Policy holder - LUCIO GONZALEZ ARTURO

WCB# -

Carrier case # -

Attorney - Firm Name -

Attorney Address -

Attorney Phone - Fax -

Contact Person -

Other Insurance -

Medicare -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Lucio Gonzalez, Arturo

Date of Birth: 05/10/1980

Date of Accident: 01/15/2026

Date of Service: 01/20/2026

The patient states that he/she was in a MVA / WC related accident and was a driver / passenger (front/rear)

After the accident he went to X hospital / Urgent

Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 45 years-old male / female who presented in my office with following complaints:

- Neck pain.
- Upper / Lower back pain.
- Shoulders pain (Right / Left / Both)
- Knee pain (Right / Left / Both)
- Elbow pain (Right / Left / Both)
- Ankle pain (Right / Left / Both)
- Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine

Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.

Thorax : No deformities were noted.

Eyes: Pupils were round, regular and equal. They reacted normally to light.

Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance - Good, Patient is cooperative. Height: 5-3", Weight: 175 Lbs.,

HEENT: Normal

Abdomen: No complaints of masses, tenderness or rigidity and noted.

Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, _____, ("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.

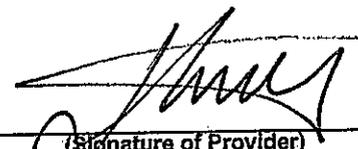
Antonio Lugo Gonzalez
(Print name of Patient)


(Signature of Patient)

01/22/26
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)


(Signature of Provider)

3412 BLUESTONE LANE

01/22/26
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

Parent 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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: _____

Date: _____

01/22/26

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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: _____

Date: _____

01/22/26

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: _____

01/22/26

(01313)-RODRIGUEZ LUIS DAVID

Date of Birth - 8/31/1981 Sex - Male Marital Status - Single

Address: 363 E 180TH,The Bronx,NY,10457
Phone #: (929) 442-5266

Social Security# -

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 1/5/2026

Time/Place Accident - FAILE ST AND SENECA

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 8811402940000001

Claim Address - GEICO NY PIP

PO Box 9506

Fredericksburg, VA 22403-9506

Policy Adjuster - Morgan Ottaiano

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 -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Rodriguez Luis, David
 Date of Birth: 08/31/1981
 Date of Accident: 01/05/2026
 Date of Service: 01/15/2026

The patient states that he/she was in a MVA / WC related accident and was a driver / passenger (front/rear) Lincoln hospital / Urgent
 After the accident he went to Lincoln hospital / Urgent
 Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 44 years-old male / female who presented in my office with following complaints:

- Neck pain.
- Upper / Lower back pain.
- Shoulders pain (Right / Left / Both)
- Knee pain (Right / Left / Both)
- Elbow pain (Right / Left / Both)
- Ankle pain (Right / Left / Both)
- Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine
 Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.
 Thorax : No deformities were noted.
 Eyes: Pupils were round, regular and equal. They reacted normally to light.
 Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance -Good, Patient is cooperative. Height: 5-8" , Weight: 150 Lbs.,
 HEENT: Normal

Abdomen: No complaints of masses, tenderness or rigidity and noted.

Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, _____, ("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.

Luis David Rodriguez
(Print name of Patient)

[Signature]
(Signature of Patient)

01/22/26
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

01/22/26
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

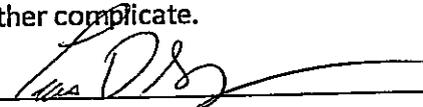
EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

Parent 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 point I know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 01/22/26

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 point I
know of no other condition which the taking of x-rays would further complicate.

Signed: _____ Date: 01/22/26

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: 01/22/26

(01314)-AGOSTO WILLIAM F

Date of Birth - 1/18/1966 Sex - Male Marital Status - Single

Address: 363 E 180TH,The Bronx,NY,10457

Phone #: (332) 400-6226

Social Security# - 088-56-3412

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 1/5/2026

Time/Place Accident - FAILE ST AND SENECA

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 8811402940000001

Claim Address - GEICO NY PIP

PO Box 9506

Fredericksburg, VA 22403-9506

Policy Adjuster - Morgan Ottaiano

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 -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Agosto, William

Date of Birth: 01/18/1966

Date of Accident: 01/05/2020

Date of Service: 01/15/2020

The patient states that he/she was in a MVA / WC related accident and was a driver / passenger (front/rear)

After the accident he went to Kaiser hospital / Urgent

Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 59 years-old-male / female who presented in my office with following complaints:

- Neck pain.
- Upper / Lower back pain.
- Shoulders pain (Right / Left / Both)
- Knee pain (Right / Left / Both)
- Elbow pain (Right / Left / Both)
- Ankle pain (Right / Left / Both)
- Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine

Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.

Thorax : No deformities were noted.

Eyes: Pupils were round, regular and equal. They reacted normally to light.

Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance - Good, Patient is cooperative. Height: 5-10", Weight: 190 Lbs.,

HEENT: Normal

Abdomen: No complaints of masses, tenderness or rigidity and noted.

Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, William Agosto, ("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.

William Agosto
(Print name of Patient)

William Agosto
(Signature of Patient)

01/22/26
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

01/22/26
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

(01315)-FAGAN DENESIA S

Date of Birth - 4/21/1995 Sex - Female Marital Status - Married

Address: 100 E 182ND ST,The Bronx,NY,10453

Phone #: (646) 425-7089

Social Security# - XXX-XX-4831

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 1/3/2026

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 - PROCESSING CENTER 5 BROADWAY
FREEPORT NY 11520

Policy Effective Date -

Policy# -

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 - 718-223-5953

Contact Person -

Other Insurance -

Medicare -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Fagan, Danesia

Date of Birth: 04/21/1995

Date of Accident: 01/03/2026

Date of Service: 01/13/2026

The patient states that he/she was in a (MVA / WC) related accident and was a driver / passenger (front/rear). After the accident he went to Westchester Presbyterian hospital / Urgent. Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 30 years-old- male / female who presented in my office with following complaints:

- Neck pain.
- Upper / Lower back pain.
- Shoulders pain (Right / Left / Both)
- Knee pain (Right / Left / Both)
- Elbow pain (Right / Left / Both)
- Ankle pain (Right / Left / Both)
- Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

- Allergies: No known allergy to any medicine
- Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.
- Thorax : No deformities were noted.
- Eyes: Pupils were round, regular and equal. They reacted normally to light. Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance - Good, Patient is cooperative. Height: 5-4", Weight: 170 Lbs.,
 HEENT: Normal
 Abdomen: No complaints of masses, tenderness or rigidity and noted.
 Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, Denesia Sagan, ("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.

Denesia Sagan
(Print name of Patient)

D Sagan
(Signature of Patient)

01/22/26
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

01/22/26
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301
Tel: (570) 243-1888

X-Ray Consent Form

Parent 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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: Dagan Date: 01/22/26

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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: _____ Date: 01/22/26

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: Dagan Date: 01/22/26

(01235)-PEREZ ROSARIO JUNIOR P

Date of Birth - 10/23/1997 Sex - Male Marital Status - Single

Address: 1278 GRANT CONCOURSE, BRONX, NY, 10456
Phone #: (929) 583-9431

Social Security# - 268-55-7912

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 : Allstate Fire and Casualty Insurance Company

Address:

Phone: Fax:

Claim# - 0811891092

Claim Address - ALLSTATE INS CLAIMS
P.O. BOX 660636
DALLAS, TX 75266

NF-2 - Yes Sending Date - 12/17/2025

Policy Effective Date -

Policy# - 933337689

Policy holder - NUNEZ, PEDRO

WCB# -

Carrier case # -

To 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 -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Perez, Junior
 Date of Birth: 10/23/1997
 Date of Accident: 11/17/2025
 Date of Service: 11/20/2025

The patient states that he/she was in a MVA WC related accident and was a driver / passenger (front/rear)

After the accident he went to X hospital / Urgent

Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 28 years-old male female who presented in my office with following complaints:

- Neck pain.
- Upper / Lower back pain.
- Shoulders pain (Right / Left / Both)
- Knee pain (Right / Left / Both)
- Elbow pain (Right / Left / Both)
- Ankle pain (Right / Left / Both)
- Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine

Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.

Thorax : No deformities were noted.

Eyes: Pupils were round, regular and equal. They reacted normally to light.

Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance -Good, Patient is cooperative. Height: 5-6", Weight: 172 Lbs.,

HEENT: Normal

Abdomen: No complaints of masses, tenderness or rigidity and noted.

Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, Junior Rapael ("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.

Junior Rapael
(Print name of Patient)

Junior Rapael
(Signature of Patient)

01/22/26
(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)

01/22/26
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

Parent 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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: Judy Date: 01/22/26

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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: Judy Date: 01/22/26

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: Judy Date: 01/22/26

(01215)-RAMOS WILFREDO

Date of Birth - 3/15/1996 Sex - Male Marital Status - Single

Address: 550 W 125 ST,New York,NY,10027
Phone #: (646) 941-0493

Social Security# - XXX-XX-XXX

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 11/6/2025

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# - 250954571

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

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

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 -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Ramos, Wilfredo
 Date of Birth: 03/15/1996
 Date of Accident: 11/06/2025
 Date of Service: 11/11/2025

The patient states that he/she was in a MVA / WC related accident and was a driver / passenger (front/rear)
 After the accident he went to _____ hospital / Urgent
 Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 29 years-old male / female who presented in my office with following complaints:

- Neck pain.
- Upper / Lower back pain.
- Shoulders pain (Right / Left / Both)
- Knee pain (Right / Left / Both)
- Elbow pain (Right / Left / Both)
- Ankle pain (Right / Left / Both)
- Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine
 Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.
 Thorax : No deformities were noted.
 Eyes: Pupils were round, regular and equal. They reacted normally to light.
 Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance - Good. Patient is cooperative. Height: 5-9", Weight: 150 Lbs.,
 HEENT: Normal
 Abdomen: No complaints of masses, tenderness or rigidity and noted.
 Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, _____, ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights 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.

Wilfredo Ramos
(Print name of Patient)

[Signature]
(Signature of Patient)

01/22/26
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

01/22/26
(Date of signature)

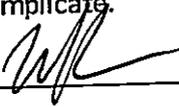
EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301
Tel: (570) 243-1888

X-Ray Consent Form

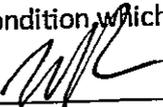
Parent Consent To X-Ray:

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

Signed:  Date: 01/22/26

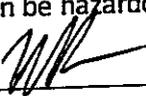
Consent To X-Ray:

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 point I
know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 01/22/26

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: 01/22/26

(01326)-GONZAGA VILMA MARITZA

Date of Birth - 3/3/1957 Sex - Female Marital Status - Married

Address: 1662 VYSE AVE, The Bronx, NY, 10460
Phone #: (347) 968-7908

Social Security# - XXX-XX-8243

Employer or Company Name:

Address:
Emergency Name:
Work Phone #:

Date of Accident - 1/12/2026

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : STATE FARM

Address:

Phone: Fax:

Claim# -

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

Policy Effective Date -

Policy# - 2750867-D14-52D

Policy holder - GONZAGA VILMA MARITZA

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 -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Gonzaga, Maritza Vima

Date of Birth: 03/03/1957

Date of Accident: 01/12/2026

Date of Service: 01/15/2026

The patient states that he/she was in a MVA / WC related accident and was a driver / passenger (front/rear)

After the accident he went to X hospital / Urgent

Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 68 years-old- male / female who presented in my office with following complaints:

- Neck pain.
- Upper / Lower back pain
- Shoulders pain (Right / Left / Both)
- Knee pain (Right / Left / Both)
- Elbow pain (Right / Left / Both)
- Ankle pain (Right / Left / Both)
- Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine

Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.

Thorax : No deformities were noted.

Eyes: Pupils were round, regular and equal. They reacted normally to light.

Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance - Good, Patient is cooperative. Height: 5-3", Weight: 240 Lbs.,

HEENT: Normal

Abdomen: No complaints of masses, tenderness or rigidity and noted.

Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

V. Eldred Gonzaga, ("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.

V. Eldred Gonzaga
(Print name of Patient)

VILMA M GONZAGA
(Signature of Patient)

01/22/26
(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)

01/22/26
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

Parent 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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: *Valeria M. Gouzberg* Date: 01/22/26

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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: _____ Date: 01/22/26

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: *Valeria M. Gouzberg* Date: 01/22/26

(01300)-ORTIZ JENNIFER A

Date of Birth - 12/3/1986 Sex - Female Marital Status - Single

Address: 753 FOX ST #2F,The Bronx,NY,10455
Phone #: 1929) 922-1270

Social Security# -

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 12/14/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 882852965000000

Claim Address - GEICO NY PIP

PO Box 9506

Fredericksburg, VA 22403-9506

NF-2 - Yes Sending Date - 01/15/2026

Policy Effective Date -

Policy# -

Policy holder - ORTIZ,JENNIFER

WCB# -

Carrier case # -

Attorney - KOVAL & ASSOCIATES, P.C Firm Name - KOVAL & ASSOCIATES, P.C

Attorney Address - 1010 Northern Blvd Suite 232 Great Neck, New York 11021

Attorney Phone - 718-281-4200 Fax - 718-281-2600

Contact Person -

Other Insurance -

Medicare -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Ortiz, Jennifer
 Date of Birth: 12/03/1986
 Date of Accident: 12/14/2005
 Date of Service: 12/30/2005

The patient states that he/she was in a MVA / WC related accident and was a driver / passenger (front/rear)
 After the accident he went to X hospital / Urgent
 Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 39 years-old- male / female who presented in my office with following complaints:

- Neck pain.
- Upper / Lower back pain.
- Shoulders pain (Right / Left / Both)
- Knee pain (Right / Left / Both)
- Elbow pain (Right / Left / Both)
- Ankle pain (Right / Left / Both)
- Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine
 Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.
 Thorax : No deformities were noted.
 Eyes: Pupils were round, regular and equal. They reacted normally to light. Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance -Good, Patient is cooperative. Height: 5-3", Weight: 155 Lbs.,
 HEENT: Normal
 Abdomen: No complaints of masses, tenderness or rigidity and noted.
 Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, _____, ("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.

Jennifer Ortiz
(Print name of Patient)

Jennifer Ortiz
(Signature of Patient)

01/22/26
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

01/22/26
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

Parent 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 point I know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 01/22/26

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 point I know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 01/22/26

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: 01/22/26

(01301)-CARABALLO MICHELLE

Date of Birth - 1/7/1978 Sex - Female Marital Status - Single

Address: 753 FOX ST 2F, BRONX, NY, 10455
Phone #: (917) 246-3612

Social Security# - 000-00-0000

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 12/14/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 882852965000000

Claim Address - GEICO NY PIP

PO Box 9506

Fredericksburg, VA 22403-9506

NF-2 - Yes Sending Date - 01/14/2026

Policy Effective Date -

Policy# - 6179055949

Policy holder - JENNIFER ORTIZ

WCB# -

Carrier case # -

Attorney - KOVAL & ASSOCIATES, P.C Firm Name - KOVAL & ASSOCIATES, P.C

Attorney Address - 1010 Northern Blvd Suite 232 Great Neck, New York 11021

Attorney Phone - 718-281-4200 Fax - 718-281-2600

Contact Person -

Other Insurance -

Medicare -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Caraballo, Michelle
 Date of Birth: 01/07/1978
 Date of Accident: 12/14/2025
 Date of Service: 12/30/2025

The patient states that he/she was in a MVA / WC related accident and was a driver / passenger (front/rear)
 After the accident he went to X hospital / Urgent
 Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 47 years-old- male / female who presented in my office with following complaints:

- Neck pain.
- Upper / Lower back pain.
- Shoulders pain (Right / Left / Both)
- Knee pain (Right / Left / Both)
- Elbow pain (Right / Left / Both)
- Ankle pain (Right / Left / Both)
- Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine
 Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.
 Thorax : No deformities were noted.
 Eyes: Pupils were round, regular and equal. They reacted normally to light.
 Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance - Good, Patient is cooperative. Height: 5-4" Weight: 150 Lbs.,
 HEENT: Normal

Abdomen: No complaints of masses, tenderness or rigidity and noted.

Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, _____, ("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.

Michelle Caraballo
(Print name of Patient)

Michelle Caraballo
(Signature of Patient)

01/22/26
(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)

01/22/26
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

Parent 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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: Michelle Caraballo Date: 01/22/26

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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: _____ Date: 01/22/26

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: Michelle Caraballo Date: 01/22/26

(01330)-BAEZ MESHELL V

Date of Birth - 1/18/1997 Sex - Male Marital Status - Single

Address: 230 W 126TH,New York,NY,10027

Phone #: (929) 702-9192

Social Security# - 084-86-4390

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 1/16/2026

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : State Farm Insurance

Address:

Phone: Fax:

Claim# -

Claim Address - STATE FARM INSURANCE

P.O BOX 2358

BLOOMINGTON IL 61702 - 2358

Policy Effective Date -

Policy# - 374 6349 - C08-52

Policy holder - BAEZ MICHAEL ,RODRIGUEZ CRISTINA

WCB# -

Carrier case # -

Attorney - KOVAL & ASSOCIATES, P.C Firm Name - KOVAL & ASSOCIATES, P.C

Attorney Address - 1010 Northern Blvd Suite 232 Great Neck, New York 11021

Attorney Phone - 718-281-4200 Fax - 718-281-2600

Contact Person -

Other Insurance -

Medicare -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Baez, meshell

Date of Birth: 01/18/1997

Date of Accident: 01/16/2026

Date of Service: 01/20/2026

The patient states that he/she was in a MVA / WC related accident and was a driver / passenger (front/rear)

After the accident he went to _____ hospital / Urgent

Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 29 years-old- male / female who presented in my office with following complaints:

- Neck pain.
- Upper / Lower back pain.
- Shoulders pain (Right / Left / Both)
- Knee pain (Right / Left / Both)
- Elbow pain (Right / Left / Both)
- Ankle pain (Right / Left / Both)
- Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine

Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.

Thorax : No deformities were noted.

Eyes: Pupils were round, regular and equal. They reacted normally to light.

Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance -Good, Patient is cooperative. Height: 5-8 ", Weight: 245 Lbs.,

HEENT: Normal

Abdomen: No complaints of masses, tenderness or rigidity and noted.

Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, Me'shell Baez, ("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 1-16-26, 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.

Me'shell Baez
(Print name of Patient)


(Signature of Patient)

230 West 126 Street Apt 6E

01/22/26
(Date of signature)

NY, NY 10027
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)


(Signature of Provider)

3412 BLUESTONE LANE

01/22/26
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

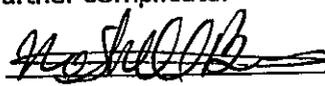
EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

Parent 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 point I know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 01/22/26

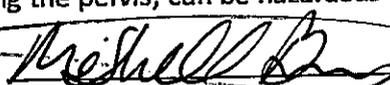
Consent To X-Ray:

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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: _____ Date: 01/22/26

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: 01/22/26

(01331)-VASQUEZ ESGARE S

Date of Birth - 9/7/1984 Sex - Male Marital Status - Single

Address: 418 E 182 ST, New York, NY, 10457

Phone #: (347) 951-3042

Social Security# - 052-76-3382

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 1/13/2026

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO INSURANCE COMPANY

Address:

Phone: Fax:

Claim# -

Claim Address - 100 WILLIAM STREET 14TH, FLOOR
NEWYORK, NY 10038

Policy Effective Date -

Policy# - 4621423682

Policy holder - NUNEZ PEREZ MANUEL

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 -



OAK STREET MEDICAL, PC

1955 SOUTHERN BLVD 2ND FL, BRONX, NY 10460

Office #: 917-451-1447

OAKSTREETMED@GMAIL.COM

Initial Evaluation / Follow-Up

Patient's Name: Vasquez, Esgare
 Date of Birth: 09/07/1984
 Date of Accident: 01/13/2006
 Date of Service: 01/20/2006

The patient states that he/she was in a MVA / WC related accident and was a driver / passenger (front/rear)

After the accident he went to X hospital / Urgent

Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 42 years-old male / female who presented in my office with following complaints:

Neck pain.

Upper / Lower ~~back~~ back pain.

Shoulders pain (Right / Left / Both)

Knee pain (Right / Left / Both)

Elbow pain (Right / Left / Both)

Ankle pain (Right / Left / Both)

Any other _____

PREVIOUS HISTORY: There is no significant past medical history of MVA or any major surgery. The patient denies drug addiction and alcoholism.

FAMILY HISTORY:

Family history is non-contributory.

SOCIAL AND PERSONAL HISTORY:

Allergies: No known allergy to any medicine

Head : The facial muscles were intact and there were no masses, tenderness, laceration, or abrasions.

Thorax : No deformities were noted.

Eyes: Pupils were round, regular and equal. They reacted normally to light.

Extraocular movements were full in all fields gaze with no nystagmus apparent.

GENERAL EXAMINATION:

Appearance -Good, Patient is cooperative. Height: 6-0^y, Weight: 287 Lbs.,

HEENT: Normal

Abdomen: No complaints of masses, tenderness or rigidity and noted.

Lymph nodes: The cervical, auxiliary, supra clavicular, and inguinal lymph nodes are not enlarged.

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

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

Claim Number: _____

I, ESgare Vasquez, ("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.

ESgare Vasquez
(Print name of Patient)

ESgare Vasquez
(Signature of Patient)

01/22/26
(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)

01/22/26
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

Parent Consent To X-Ray:

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Signed: _____ Date: 01/22/26

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 point I know of no other condition which the taking of x-rays would further complicate.

Signed: _____ Date: 01/22/26

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: 01/22/26