

2354 WESTCHESTER
+ RAYS

01/27/26

DATE: _____

X-RAY LIST

NAME:	NOTE:	
1. OTERO DESTINY		
2. MALDONADO FELIX		
3. BERROCAL ARMANI		
4. ALMONTE JORDY		
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20.		



MOBILE PORTABLE X-RAY ORDER FORM

DATE 01/27/2008

YOUR INFORMATION:

NAME ALMONTE JORDY D.O.B. 06/17/03 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY .. Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES.. Complete 3 or more views <input type="checkbox"/> 70150</p> <p>FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND Complete 3 views - R <input type="checkbox"/> <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input checked="" type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES .. Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views <input type="checkbox"/> 70360</p> <p>ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> 73030</p> <p>SI JOINTS Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views <input type="checkbox"/> 71120</p> <p>THORACIC 2 views <input checked="" type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY EXTREMITY Lower. 2 views <input type="checkbox"/> 73592 EXTREMITY Upper. 2 views <input type="checkbox"/> 73092 PELVIS & HIPS .. min. 2 views <input type="checkbox"/> 73540 WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100 OTHER</p>
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REQUESTING PHYSICIAN:

NAME SCARBOROUGH PAUL DR. NPI# 1649289547 FAX RESULTS TO () _____
 INDICATE REASON FOR STUDY A/D FX/PAIN/PATHOLOGY SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN _____ TECHNIQUE _____ # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST _____ DATE X-RAY SENT / / _____ PATIENT ID # _____ # OF CD _____

NOTE TO OFFICIALS: A portable X-RAY is being ordered since this patient would find it physically and/or psychologically taxing, because of advanced age and/or physical limitations to receive X-RAY outside the home. This test is medically necessary for the diagnosis and treatment of this patient.



DYNAMIC
MOBILE XRAY SERVICES LLC

Phone: (570)243-1888
Fax: 570-209-5771

Email: dynamicmobilexrays@gmail.com
website: dynamicmobilexray.com

MOBILE PORTABLE X-RAY ORDER FORM

DATE 01/27/2018

YOUR INFORMATION:

NAME BERROCAL ARMANI D.O.B. 11/13/98 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE..... 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY.. Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input checked="" type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views .. <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES.. Complete 3 or more views..... <input type="checkbox"/> 70150</p> <p>FEMUR..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p>HEEL..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input checked="" type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views..... <input type="checkbox"/> 72114 Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES.. Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views..... <input type="checkbox"/> 70360</p> <p>ORBITS..... Complete 4 views..... <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views Includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views..... <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views -R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS..... 3 views..... <input type="checkbox"/> 71130</p> <p>SHOULDER..... Complete, 2 views - R <input type="checkbox"/> L <input checked="" type="checkbox"/> 73030</p> <p>SI JOINTS..... Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less..... <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less..... <input type="checkbox"/> 70250 Complete 4 views..... <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views..... <input type="checkbox"/> 71120</p> <p>THORACIC..... 2 views..... <input checked="" type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views..... <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ..... Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY</p> <p>EXTREMITY Lower. 2 views..... <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views..... <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS .. min. 2 views..... <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME SCARBOROUGH PAUL DR. NPI# 1649289547 FAX RESULTS TO () _____
 INDICATE REASON FOR STUDY A/D FX/PAIN/PATHOLOGY SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN _____ TECHNIQUE _____ # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST _____ DATE X-RAY SENT 1/1/18 PATIENT ID # _____ # OF CD _____

NOTE TO OFFICIALS: A portable X-RAY is being ordered since this patient would find it physically and/or psychologically taxing, because of advanced age and/or physical limitations to receive X-RAY outside the home. This test is medically necessary for the diagnosis and treatment of this patient.



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Fax: 570-209-5771

Email: dynamicmobilexrays@gmail.com

website: dynamicmobilexray.com

MOBILE PORTABLE X-RAY ORDER FORM

DATE 01/27/2008

YOUR INFORMATION:

NAME MALDONADO FELIX D.O.B. 7/31/99 SS# _____ MALE FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____

FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE NAME _____ INSURANCE ID # _____

SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views..... <input type="checkbox"/> 74020 Acute w/chest 3 views..... <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views..... <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE..... 1 view..... <input type="checkbox"/> 77072</p> <p>BONE SURVEY.. Complete..... <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views..... <input checked="" type="checkbox"/> 72040 Complete w/min. 4 views..... <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views..... <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view..... <input type="checkbox"/> 71045 Complete 2 views..... <input type="checkbox"/> 71046 Complete w/lordotic 3 views..... <input type="checkbox"/> 71047 Complete 4 views..... <input type="checkbox"/> 71048 Special views Decubitus..... <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES.. Complete 3 or more views..... <input type="checkbox"/> 70150</p> <p>FEMUR..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # ____ . Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND..... Complete 3 views - R <input type="checkbox"/> 73130</p> <p>HEEL..... Complete 2 views - R <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views..... <input checked="" type="checkbox"/> 72100 Complete 4 views w/obl..... <input type="checkbox"/> 72110 Complete w/bending 7 views..... <input type="checkbox"/> 72114 Limited w/bending 4 views..... <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views..... <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES.. Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views..... <input type="checkbox"/> 70360</p> <p>ORBITS..... Complete 4 views..... <input type="checkbox"/> 70200 MRI screening..... <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views..... <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS..... 3 views..... <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> 73030</p> <p>SI JOINTS..... Complete, 2 views..... <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less..... <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less..... <input type="checkbox"/> 70250 Complete 4 views..... <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views..... <input type="checkbox"/> 71120</p> <p>THORACIC 2 views..... <input checked="" type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views..... <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ..... Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY</p> <p>EXTREMITY Lower. 2 views..... <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views..... <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS .. min. 2 views..... <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME SCARBOROUGH PAUL DR. NPI# 1649289547 FAX RESULTS TO () _____

INDICATE REASON FOR STUDY A/D FX/PAIN/PATHOLOGY SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN _____ TECHNIQUE _____ # OF VIEWS _____

X-RAY SENT TO RADIOLOGIST _____ DATE X-RAY SENT ____ / ____ / ____ PATIENT ID # _____ # OF CD _____

NOTE TO OFFICIALS: A portable X-RAY is being ordered since this patient would find it physically and/or psychologically taxing, because of advanced age and/or physical limitations to receive X-RAY outside the home. This test is medically necessary for the diagnosis and treatment of this patient.

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MOBILE PORTABLE X-RAY ORDER FORM

DATE 01/27/2006

YOUR INFORMATION:

NAME OTERO DESTINY D.O.B. 7/24/93 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE (____) _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY .. Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input checked="" type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES.. Complete 3 or more views <input type="checkbox"/> 70150</p> <p>FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input checked="" type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES .. Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views <input type="checkbox"/> 70360</p> <p>ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p>SI JOINTS Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views <input type="checkbox"/> 71120</p> <p>THORACIC 2 views <input checked="" type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY</p> <p>EXTREMITY Lower. 2 views <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS .. min. 2 views <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME SCARBOROUGH PAUL DR. NPI# 1649289547 FAX RESULTS TO (____) _____
 INDICATE REASON FOR STUDY A/O FX/PAIN/PATHOLOGY SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN _____ TECHNIQUE _____ # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST _____ DATE X-RAY SENT ____/____/____ PATIENT ID # _____ # OF CD _____

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PATIENT DEMOGRAPHIC FORM 01/27/2026

BERROCAL, ARMANI

DOB: 11/13/1998

Cell Phone: 347-409-0766

Sex: Male

Home phone:

DOA: 12/20/2025

Social Security Number: 080-88-8907

Case type: No Fault

Address: 2 FORTUNE ROAD W APT 2A, Middletown, NY, 10:

Primary Insurance: GEICO

Address: P.O. BOX 9507, Fredericksburg, VA, 22403

Claim Number: 8820836890000001

Policy Number: 6170900531

Policy Holder: BERROCAL, ARMANI

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: THE CHERNY LAW OFFICE

Address: 171 Westwood Ave fl.1, Staten Island, NY, 10314

Phone number: 718-494-7100

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

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

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

Claim Number: _____

I, Armani Berrault ("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.

Armani Berrault
(Print name of Patient)

[Signature]
(Signature of Patient)

01/27/26
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

01/27/26
(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: _____

1/21/26

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: _____

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: _____

406 MEDICAL P.C

409 ROCKAWAY AVENUE, 2ND FL.
BROOKLYN, NY 11212



TEL: 718-513-5881
FAX: 347-295-3974

NAME: Berrocchi Armani
DATE OF CONSULTATION: 1/12/26

D.O.B.: 11/13/1998
Date of Accident: 12/20/2025

INITIAL EXAMINATION REPORT

HISTORY OF PRESENT CONDITION:

[Mr.] [Mrs.] Armani Berrocchi is a 27 year old [M] [F], who was involved in a [MVA] [SF] [WC] accident. The details of the accident have been discussed with the patient. According to the information presented, the patient was in a regular state of good health/chronic health and was capable of living on an equal basis with others of same age, before the he/she was involved in an accident on (date) 12/20/25.

This patient was the [driver, [passenger, [pedestrian, [bicyclist), seated in the Driver's seat, [with] [without] a seatbelt. The patient reported [loss of consciousness for approximately _____] [no loss of consciousness. The patient reports the following incident:

It reported he was the driver of vehicle, was about to make a left turn, suddenly overrode by vehicle, there was another person in the car. It happened by Adams of the Hudson Valley as a residence.

Following the accident, the patient states that he/she [was] [was not] treated by EMS, and [was] [was not] transported to the emergency room of Garnett by [EMS, [a friend, [self] on the [same, [next] day.

According to the examination, the patient sustained injuries to:

- HEAD
- NECK
- MIDDLE BACK
- LOWER BACK
- KNEE Right Left
- SHOULDERS Right Left

[] LACERATIONS [] WOUNDS [] BRUISES in the _____ with _____ discoloration of the skin in the _____ area.

[] OTHER _____

The patient had [] X-rays [] CT scans [] MRI of the _____

[] Patient reports there was no evidence of fracture or dislocations.
[] The patient was hospitalized for _____ The patient was given [] medication [] supplies and was discharged.
[] The patient was treated by his/ her primary care physician on 1/12/26.
[] The patient treated themselves with analgesics with mild effect. The patient's condition became worse, and he/she came in for a consultation on 1/12/26.

PATIENT: _____

406 MEDICAL P.C

409 ROCKAWAY AVENUE, 2ND FL.
BROOKLYN, NY 11212



TEL: 718-513-5881
FAX: 347-295-3974

NAME: _____

D.O.B.: _____

DATE OF CONSULTATION: _____

Date of Accident: _____

PREVIOUS MEDICAL/ SURGICAL HISTORY

Non-contributory Diabetes HTN CAD OA

other _____

CURRENT MEDICATION

No medication Tylenol Ibuprofen other _____

ALLERGIES

No Allergies Allergy to PCN, Amoxicillin

Patient states he she has had not had a MVA in the past year _____
For female patient)

Patient is pregnant and at _____ weeks gestational age with EDC ____/____/____

Patient is not pregnant and last menstrual period was ____/____/____

Patient is post-menopausal N/A

FAMILY & SOCIAL HISTORY

Non-contributory

Smoke Yes NO

Alcohol YES NO

Other _____ Socially Socially

PHYSICAL EXAMINATION

GENERAL APPEARANCE:

Well developed and well nourished _____ year old M F. AAO x3

Normocephalic, no neck masses, no bruits, ear canals are clear, no oropharyngeal erythma. Abdomen with good bowel sound without guarding, rigidity or rebound. No clubbing or cyanosis noticed on upper/lower extremities. Pulses present bilaterally are equal. Non-gross deformities or focal deficits are noticed.

Patient appears to be in mild moderate severe distress due to pain and discomfort of the _____

Vital Signs

BP 120/66 Pulse: 70 BPM Regular Irregular, RR 16

Weight 65 lbs. Height 6'1"

PATIENT: _____

406 MEDICAL P.C

409 ROCKAWAY AVENUE, 2ND FL.
BROOKLYN, NY 11212



TEL: 718-513-5881
FAX: 347-295-3974

NAME: _____

D.O.B.: _____

DATE OF CONSULTATION: _____

Date of Accident: _____

CURRENT CHIEF COMPLAINTS & REVIEW SYSTEM

Head/ Headaches:

PAIN SCALE: 7 /10

Constant Intermittent headaches _____ area, with dizziness, vertigo, blurred vision, nausea, hearing loss in the _____ ear. nervousness, anxiety, fears, irritability, tension, poor memory, insomnia. The patient is alert, awake, oriented to person, time and place. Normal affect, speech, and attention span as well as memory, (both short and long) appear intact.

Saw crepitus, heard with yawning

Chest:

PAIN SCALE: 0 /10

No tenderness or pain on palpation.
 Constant Intermittent anterior chest wall pain noted.
 There was pain noted over the sternum and ribs with without deep breathing or cough, with without palpation.

Cervical Spine:

PAIN SCALE: 5 /10

Normal examination of the cervical spine.
 There was decreased range of motion in the cervical spine.
 Neck pain and stiffness with without pain radiating to the _____ ()
Flexion 30 (45) degrees, Extension 5 (30) degrees, Right rotation 60 (75), Left rotation 60 (75) degrees, Lateral bending 30 (45)
Examination of the neck reveals cervical spine tenderness at the C 2 C 6 levels.
There is no feeling an anterior step-off or displacement of a spinous processes on its adjacent lower neighbor to suggests spondylolisthesis near the R L muscle bone in the Para vertebral trapezius rhomboid muscles. The patient states there is pain paresthesia numbness tingling sensation in the L R upper extremities and _____
Compression test Positive Negative
Distraction test Positive Negative

Thoracic Spine:

PAIN SCALE: 0 /10

There was no pain and tenderness noted for the thoracic spine.
 There appears to be tenderness of the Thoracic Spine at the T _____ T _____ level with spasm in the right/ left Para spinal structures. No Step-Off appreciated. There is no feeling an anterior step-off or displacement of a spinous processes on its adjacent lower neighbor to suggest spondylolisthesis near par vertebral muscles.

PATIENT: _____

406 MEDICAL P.C

409 ROCKAWAY AVENUE, 2ND FL.
BROOKLYN, NY 11212



TEL: 718-513-5881
FAX: 347-295-3974

NAME: _____

D.O.B.: _____

DATE OF CONSULTATION: _____

Date of Accident: _____

Lumbosacral Spine:

PAIN SCALE: 5-6 /10

- Normal examination of the lumbar spine.
- There was decreased range of motion in the lumbar spine.
- Flexion 40 (80) degrees, extension 30 (30) degrees; right lateral flexion 30 (30) degrees, left lateral flexion _____ (30) degrees, rotation 40 (40)
- Lower back pain and stiffness with without pain radiating to the _____

Examination of the lumbosacral spine revealed tenderness at the L 4 L 5 S 1 levels with increase { } R { } L para vertebral muscle tone. There is no feeling an anterior step-off or displacement of spinous processes on its adjacent lower neighbor to suggest spondylolisthesis near paravertebral muscles of LS spine. The patient states there is pain paresthesias numbness tingling sensation in the { } R { } L lower extremities and _____

Spinal Percussion Test Positive Negative _____

Straight leg Raise Test Positive Negative _____ on the right and _____ on the left.

Upper Extremities:

PAIN SCALE: 3-4 /10

- Examination of the Upper extremities was normal.
- Examination of the extremities reveals tenderness over the _____ and crepitus is noticed upon manipulation of the area.
- Active and passive moments are restricted and painful or palpation of the L Shoulder
- Shoulder Abduction 90 (150) degrees, Elevation 90 (150) degrees, Internal rotation 20 (40) degrees, and external rotation 90
- Crepitus is appreciated { } right { } left subacromial/ subdeltoid bursa.
- Able { } unable to elevate and hold { } right { } left arm at above shoulder level.
- Other _____

Lower Extremities:

PAIN SCALE: 8-9 /10

- Examination of the Lower extremities was normal.
- Examination of the extremities reveals tenderness over the _____ and crepitus. Flexion 90 (150) degrees, Internal tibial rotation 20 (40) degrees and external rotation 20 (50) degrees.
- Edema was noted _____ Active and passive moments are restricted and painful on palpation of the _____
- Anterior Draw sign in Positive Negative on { } right { } left.
- Lachman test is Positive Negative on { } right { } left
- Varus Stress test is Positive Negative Valgus Stress is Positive Negative

PATIENT: _____

406 MEDICAL P.C

409 ROCKAWAY AVENUE, 2ND FL.
BROOKLYN, NY 11212



TEL: 718-513-5881
FAX: 347-295-3974

NAME: _____

D.O.B.: _____

DATE OF CONSULTATION: _____

Date of Accident: _____

NEUROLOGIC EXAMINATION:

Mental status:

The patient is alert, attentive, and oriented. Speech is clear and fluent with good repetition, comprehension, and naming. She recalls 3/3 objects at 5 minutes.

CRANIAL NERVE EXAM:

Olfaction is intact, pupils are equal and reactive to light and accommodation. Extra ocular movements are intact, and no nystagmus noted. Facial movements, smile, nasolabial fold is symmetric and facial sensation is intact. Jaw closure and opening appears symmetric. Tongue protrudes and is midline. Soft palate is elevated, and uvula is midline. Hearing is preserved. The gag reflex is preserved, and swallowing is intact. Sternocleidomastoid and trapezius muscles are strong bilaterally. No pronator drifts.

COORDINATION EXAM:

Normal finger-to-nose, heel-to-shin exam. The patient follows rapid hand alteration movements well, both with eyes closed. Gait was normal as well as heel-to-toe tandem with no ataxia, and no shuffling

MOTOR SYSTEMS

Motor Muscles test were S/S throughout.

No muscle atrophy is noted

Deep Tendon Reflexes were as noted:

Reflexes:

Biceps

Triceps

Brachioradialis

Knee jerk

Ankle jerk

Plantar Flexor

	Right	Left
Biceps	<u>2+</u>	<u>2+</u>
Triceps	<u>2+</u>	<u>2+</u>
Brachioradialis	<u>2+</u>	<u>2+</u>
Knee jerk	<u>2+</u>	<u>2+</u>
Ankle jerk	<u>2+</u>	<u>2+</u>
Plantar Flexor	<u>2+</u>	<u>2+</u>

SENSORY SYSTEM:

Sensory examination of Upper extremities revealed normal sensitivity

Sensory examination of Upper extremities revealed decreased response to light touch and pinprick sensation in the _____

Sensory examination of Lower extremities revealed normal sensitivity.

Sensory examination of Lower extremities revealed decreased response to light touch and pinprick sensation in the _____

PATIENT: _____

406 MEDICAL P.C

409 ROCKAWAY AVENUE, 2ND FL.
BROOKLYN, NY 11212



TEL: 718-513-5881
FAX: 347-295-3974

NAME: _____ D.O.B.: _____
DATE OF CONSULTATION: _____ Date of Accident: _____

Medications: Cyclobenzaprine ER Vimovo Tab Lidocaine Oint
 Tylenol
 Ibuprofen Diclofenac Sodium Ex. Gel

Based on the subjective complaints and medical evaluation of objective findings, the following test is indicated:

- X-ray (s) of the _____
- MRI/ CT- Scan of the L-shoulder, R-Quar
- Consider MRI/ CT scan of the C7 spine
- Physical therapy evaluation and treatment _____
- Computerized range of motion and muscle testing
- The patient was prescribed medical supplies such as: See Rx
- Additional Therapeutic Equipment Such As: _____
- The patient will be re-evaluated in 4 weeks

INITIAL DIAGNOSTIC IMPRESSION

Headaches _____ Post-Concussion

Sprain/ Strain of: C7L Spine, R-Quar, L-Shoulder

Contusion of: _____

Rule Out: Herniated disc, Tics

Fractures of: _____

Other: _____

PATIENT: _____

406 MEDICAL P.C

409 ROCKAWAY AVENUE, 2ND FL.
BROOKLYN, NY 11212



TEL: 718-513-5881
FAX: 347-295-3974

NAME: _____

D.O.B.: _____

DATE OF CONSULTATION: _____

Date of Accident: _____

TREATMENT PLAN:

A treatment plan was proposed and discussed with the patient. Medical treatment for the patient consists of Analgesics. The patient was advised to attend the physical therapy program at a frequency of 3 times per week for the first four weeks or until the next re-evaluation. Physical therapy will consist of various modalities such as thermotherapy (hot / cold packs), electrotherapy and electrical stimulation, cervical traction, manipulation therapy, assisted active and passive range of motion exercises for the injured areas. Additional treatment protocol was outlined with the patient being instructed for specific every day home exercises. The patient agreed to the therapy plan proposed as recommended.

CAUSALITY:

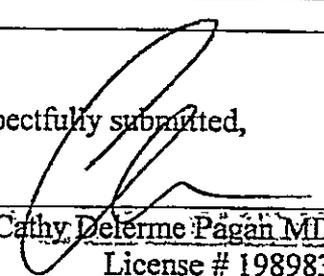
Based on medical history presented by the patient and the physical examination findings, it is my opinion to reasonable degree of medical certainty that the condition described above are solely related to and have direct cause relationship to the accident mentioned above

PROGNOSIS:

At the present time, the patient's prognosis is guarded. The possibility of this condition becoming permanent cannot be ruled out at this time. Because of the severity of the symptoms, the patient is somewhat limited in activities of daily living. If these areas remain permanently weakened for an indefinite period, this may result in significant and permanent restricted mobility.

ADDITIONAL COMMENTS:

Respectfully submitted,


Cathy DeLorme Pagan MD
License # 198983

Place of Service: 2354 Chiropractic P.C.
2354 Westchester Ave
Bronx, NY 10462
T: 718-684-4535

PATIENT: _____

PATIENT DEMOGRAPHIC FORM 01/27/2026

ALMONTE, JORDY

DOB: 06/17/2003

Cell Phone: 646-704-6363

Sex: Male

Home phone: ,

DOA: 12/19/2025

Social Security Number:

Case type: No Fault

Address: 159-14 HARLEM RIVER DRIVE APT 6C, New York, N

Primary Insurance: GEICO

Address: P.O. BOX 9507, Fredericksburg, VA, 22403

Claim Number: 8740089090000003

Policy Number:

Policy Holder: ALMONTE, JORDY

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: ALEXANDER BESPECHNY

Address: 2360 WESTCHESTER AVENUE, Bronx, NY, 10462

Phone number: 718-792-4800

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

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.

Jordy Almonte
(Print name of Patient)

Jordy Almonte
(Signature of Patient)

(Address of Patient)

01/27/26
(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)

01/27/26
(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: Jordy Almonte Date: 1/27/26

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: Jordy Almonte Date: 1/27/26

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: Jordy Almonte Date: 1/27/26

Jordan Fersel MD PC

2354 Westchester Avenue, Bronx NY 10462
 Phone No.: 718 684-4535 x FAX: 718 684-4534 x
 drmchiro2354@gmail.com

PROGRESS NOTE

Patient First Name:	Patient Last Name:	Date of Birth:	Sex:
Jordy	Almonte	06-17-2003	Male
Patient Address:		SSN:	
159 14 Haplem River Drive, 6C, New York NY 10039			
Attending Provider:	Referring Provider:	Visit Date:	Chart No.:
Jordan Fersel, M.D.		12-22-2025	SCL13202
Insurance Name:	Insurance Subscriber's ID:	Date of Injury:	Claim Id:
Appointment Location:	Appointment Location Address:	Encounter Type:	
Jordan Fersel MD PC	2354 Westchester Avenue, Bronx NY 10462	New Patient - Auto-Accident	

Chief Complaint: *Motor Vehicle Accident

Motor Vehicle Accident

Jordy Almonte is a 22 year old male who was involved in an accident on 12-19-2025. At the time of accident patient was wearing seatbelt. Patient was a driver. Patient was in the car. he suffered an impact to the left side of the vehicle and a side impact to the vehicle. Speeding car came across 2 lanes and his patients vehicle on exit lane causing his vehicle to crash into ramp. He was admitted to the ER the next day. In the ER, a physical exam was done. was then sent home Patient does not have history of back problems in the past.

Thoracic Pain

Patient reported pain is bilateral. The patient describes his pain as intermittent. Patient says, at its worse his pain is 9/10. Right now he describes his pain as 8/10 on a pain scale of 0-10.

Lumbar Spine Pain

Patient reported pain is bilateral. The patient describes his pain as constant. Patient says, at its worse his pain is 8/10. Right now he describes his pain as 8/10 on a pain scale of 0-10. The pain is made worse by bending. His pain gets better by resting.

Shoulder Pain

Patient reported pain is bilateral. L>R The patient describes his pain as constant. Patient says, at its worse his pain is 9/10. Right now he describes his pain as 8/10 on a pain scale of 0-10. The pain is made worse by lifting. His pain gets better by changing position and resting.

Hip Pain

Patient reported pain is bilateral. The patient describes his pain as intermittent. Patient says, at its worse his pain is 8/10. Right now he describes his pain as 7/10 on a pain scale of 0-10. The pain is made worse by bending. His pain gets better by changing position.

Hand Pain

Patient reported pain is bilateral. The patient describes his pain as frequent. Patient says, at its worse his pain is 5/10. Right now he describes his pain as 5/10 on a pain scale of 0-10. The pain is made worse by increased activity. His pain gets better by resting.

Ankle Pain

Patient reported pain is bilateral. R>L The patient describes his pain as intermittent. Patient says, at its worse his pain is 7/10. Right now he describes his pain as 6/10 on a pain scale of 0-10. The pain is made worse by going up stairs. His pain gets better by resting.

Review of Systems

Musculoskeletal: Reports shoulder pain, back pain, joint pain, joint stiffness and joint swelling.

Physical Examination

Thoracic Spine: There is no evidence of atrophy or asymmetry noted in the thoracic spine. There is no tenderness noted at thoracic paraspinal muscles and facet joint lines. **Range of motion of the thoracic spine is restricted with flexion and restricted with extension.** There is evidence of crepitation, laxity or instability noted in the thoracic spine. Hyperextension of thoracic spine does not cause increased pain.

Lumbar Spine: Inspection of the lumbar spine reveals no scoliosis. **Palpation of the lumbar facet reveals pain on both the sides at L3-L4 region.** There is no pain noted over the lumbar intervertebral spaces (discs) on palpation. Palpation of the bilateral sacroiliac joint area reveals no pain. Palpation of the greater trochanteric bursa on both sides reveals no tenderness. **Anterior flexion of lumbar spine is noted to be 50 degrees (ROM range 0-50 degrees).** Anterior lumbar flexion does not cause pain. Extension of lumbar spine is noted to be 30 degrees (ROM range 0-25 degrees). There is no pain noted with lumbar extension. Left lateral flexion of the lumbar spine is noted to be 25 degrees (ROM range 0-25 degrees). Left lateral flexion causes no pain. Right lateral flexion of the lumbar spine is noted to be 25 degrees (ROM range 0-25 degrees). There is no pain noted with right lateral flexion.

Joints-Shoulder: **On palpation, there is tenderness noted over the right anterior acromioclavicular joint.** Right humerus/scapula is non-tender to palpation. No right shoulder swelling noted. There is no ecchymosis noted over the right shoulder. No right sided shoulder crepitus noted. No right shoulder deformity noted. There is no atrophy of the right shoulder noted. No right shoulder effusion noted. Right Shoulder ROM: Tested. Right shoulder labral test findings: Negative. Right scapula winging grade: 0. Right shoulder bicep test: Negative. Right shoulder impingement: Negative. Right shoulder O'brien's test: Negative. Right shoulder popeye sign: Negative. Right shoulder stress test - joints: Normal. Right shoulder stress test - muscles: Normal. Reason right shoulder stress testing was not performed due to injury. **On palpation, there is tenderness noted over the left acromioclavicular joint.** Left humerus/scapula is nontender to palpation. No left shoulder swelling noted. There is no ecchymosis present over the left shoulder. No left sided shoulder crepitus noted. No left shoulder deformity noted. There is no atrophy of the left shoulder noted. No left shoulder effusion noted. Left Shoulder ROM: Tested. Left shoulder labral test findings: Negative. Left scapular winging grade: 0. Left shoulder bicep test: Negative. Left shoulder impingement test: Negative. Left shoulder O'brien's test: Negative. Left shoulder popeye sign: Negative. Left shoulder stress test - joints: Normal. Left shoulder stress test - muscles: Normal. Reason left shoulder stress testing was not performed due to injury.

Joints- Wrists: No crepitus noted over the right wrist joint. Right wrist joint is non-tender to palpation. There is no joint effusion noted in the right wrist. The right wrist joint is stable. ROM of right wrist is noted to be full. There is no crepitus noted over the left wrist joint. Left wrist is non-tender to palpation. Left wrist does not show effusion. There is stability noted in the left wrist joint. ROM of left wrist is noted to be full. Dunkan test: Negative. Phalen's sign test: No sign of altered or loss of feeling or strength, or pain in the hand, wrist, arm, or neck noted. Tinel's sign test: Negative. The patient can feel separate touches.

Joints- Ankles: The right ankle is without crepitus. Right ankle is non-tender to palpation. There is no right ankle joint effusion noted. The right ankle joint is noted to be stable. ROM is normal in the right ankle. The left ankle is without crepitus. No left ankle tenderness noted on palpation. There is no left ankle joint effusion noted. The left ankle joint is stable. ROM is normal in the left ankle.

Pain Management

- Disability Letter
- Physical Therapy Prescription

Outcomes Assessment:

Assessment and Plan

ICD: Sprain of shoulder, right (S43.401A)

ICD: Sprain of shoulder, left (S43.402A)

ICD: Thoracic back sprain (S23.9XXA)

ICD: Lumbar back sprain (S33.5XXA)

ICD: Sprain of right hip (S73.101A)

ICD: Sprain of left hip (S73.102A)

ICD: Right ankle sprain (S93.401A)

ICD: Left ankle sprain (S93.402A)

ICD: Right wrist sprain (S63.501A)

ICD: Left wrist sprain (S63.502A)

Plan

Rx Prescribed: Lidocaine 5% ointment- Topical pain management for joints and large muscle groups. Apply 2-3 times daily to the affected area.

Naprosyn 500mg every 12 hour

MRI was prescribed for Left Shoulder.

MRI was prescribed for Lumbar Spine.

MRI Was prescribed for Right ankle

Procedure

CPT Codes:

Name	Code	Units
Office O/p New Low 30 Min	99203	1.00
Prolong Service W/o Contact	99358	1.00

Prescription

lidocaine 5 % topical ointment. Apply 2-3 times per day on affected area for 30 Days , Prescribe 250 Gram

Almonte, Jordy Male 06-17-2003

Naprosyn 500 mg tablet 1 Tablet Every 12 Hours PRN for 30 Days , Prescribe 60 Tablet

Follow up: 4 Weeks

E&M Time Factor (Min): 30-44

E&M Notes: Outcome assessment was reviewed by Jordan Fersel M.D. on 12-24-2025

PATIENT DEMOGRAPHIC FORM 01/27/2026

MALDONADO, FELIX

DOB: 07/31/1999

Cell Phone: 315-418-9403

Sex: Male

Home phone:

DOA: 12/19/2025

Social Security Number: 118-88-7072

Case type: No Fault

Address: 2125 TIEBOUT AVE, Bronx, NY, 10457

Primary Insurance: GEICO

Address: P.O. BOX 9507, Fredericksburg, VA, 22403

Claim Number: 8740089090000003

Policy Number:

Policy Holder: ALMONTE, JORDY

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: ALEXANDER BESPECHNY

Address: 2360 WESTCHESTER AVENUE, Bronx, NY, 10462

Phone number: 718-792-4800

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

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

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

Claim Number: _____

I, Feliso Maldonado, ("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.

Feliso Maldonado
(Print name of Patient)

[Signature]
(Signature of Patient)

01/27/26
(Date of signature)

2125 Treadwell ave 10454 apt B8
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

01/27/26
(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: _____

01/29/20

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 point 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: _____

Jordan Fersel MD PC

2354 Westchester Avenue, Bronx NY 10462
 Phone No.: 718 684-4535 x FAX: 718 684-4534 x
 drmchiro2354@gmail.com

PROGRESS NOTE

Patient First Name:	Patient Last Name:	Date of Birth:	Sex:
Felix	Maldonado	07-31-1999	Male
Patient Address:		SSN:	
2125 Tiebout Ave , Bronx NY 10457			
Attending Provider:	Referring Provider:	Visit Date:	Chart No.:
Jordan Fersel, M.D.		12-22-2025	SCL13203
Insurance Name:	Insurance Subscriber's ID:	Date of Injury:	Claim Id:
Appointment Location:	Appointment Location Address:	Encounter Type:	
Jordan Fersel MD PC	2354 Westchester Avenue, Bronx NY 10462	New Patient - Auto-Accident	

Chief Complaint: Headache, Cervical Spine Pain, Thoracic Pain, Lumbar Spine Pain, Hip Pain, Shoulder Pain, Knee Pain, Ankle Pain

Motor Vehicle Accident

Felix Maldonado is a 26 year old male who was involved in an accident on 12-19-2025. Patient was a back seat passenger. Patient was in the car. he suffered a front impact to the vehicle and an impact to the left side of the vehicle. he suffered no loss of consciousness. He was admitted to the ER the next day. In the ER, a physical exam was done. was then sent home

Headache

Patient reports that the onset of headache was sudden. He states that his headache is recurrent. Location of headache at onset was Occipital and left temporal . Patient reports that he has same episode(s) 6 hours .

Cervical Spine Pain

Patient reported pain is bilateral. The patient describes his pain as intermittent. Patient says, at its worse his pain is 8/10. Right now he describes his pain as 6/10 on a pain scale of 0-10.

Thoracic Pain

Patient reported pain is bilateral. The patient describes his pain as intermittent. Patient says, at its worse his pain is 8/10. Right now he describes his pain as 8/10 on a pain scale of 0-10.

Lumbar Spine Pain

Patient reported pain is bilateral. The patient describes his pain as intermittent. Patient says, at its worse his pain is 9/10. Right now he describes his pain as 8/10 on a pain scale of 0-10. The pain is made worse by

bending.

Hip Pain

Patient reported pain is bilateral. The patient describes his pain as intermittent. Patient says, at its worse his pain is 8/10. Right now he describes his pain as 7/10 on a pain scale of 0-10.

Shoulder Pain

Patient reported pain is bilateral. The patient describes his pain as intermittent. Patient says, at its worse his pain is 9/10. Right now he describes his pain as 7/10 on a pain scale of 0-10. The pain is made worse by lifting. His pain gets better by resting.

Knee Pain

Patient reported pain is bilateral. R>L The patient describes his pain as intermittent. Patient says, at its worse his pain is 8/10. Right now he describes his pain as 8/10 on a pain scale of 0-10.

Ankle Pain

Patient reported pain is bilateral. The patient describes his pain as intermittent. Patient says, at its worse his pain is 7/10. Right now he describes his pain as 7/10 on a pain scale of 0-10.

Past Medical History

No Known Past Medical History

Surgical History

No Known Surgical History

Allergy

No Known Drug Allergies.

Review of Systems

Musculoskeletal: Reports neck pain, shoulder pain, back pain, joint pain and joint stiffness.

Vitals

Weight: 156.00 lbs. **Height:** 71.00 inches.

Physical Examination

Cervical Spine Exam: Inspection reveals normal curvature of the cervical spine. **The cervical spine is tender to palpation.** Palpation of the cervical facet reveals no pain. Cervical spine is noted to be stable. Anterior flexion is noted to be 55 degrees (ROM range 0-50 degrees). **No pain noted with anterior neck flexion.** Extension of cervical spine noted to be 75 degrees (ROM range 0-60 degrees). There is no pain noted with cervical spine extension. Left lateral rotation noted to be 80 degrees (ROM range 0-80 degrees). There is no pain noted with left lateral rotation of C-spine. **Left lateral flexion noted to be 40 degrees (ROM range 0-45 degrees).** **There is pain noted with left lateral flexion of C-spine.** Right lateral rotation of the C-spine is noted to be 80 degrees (ROM range 0-80 degrees). There is no pain noted with right lateral rotation. **Right lateral flexion of the C-spine is noted to be 40 degrees (ROM range 0-45 degrees).** There is no pain noted with right lateral flexion. There are no palpable trigger points in the muscles of the head and neck.

Thoracic Spine: There is no evidence of atrophy or asymmetry noted in the thoracic spine. **There is tenderness noted at paraspinal muscles.** Range of motion of the thoracic spine is normal with both flexion and extension without pain. There is evidence of crepitation, laxity or instability noted in the thoracic spine.

Hyperextension of thoracic spine does not cause increased pain.

Lumbar Spine: Inspection of the lumbar spine reveals no scoliosis. Palpation of the lumbar facet reveals no pain. There is no pain noted over the lumbar intervertebral spaces (discs) on palpation. Palpation of the bilateral sacroiliac joint area reveals no pain. Palpation of the greater trochanteric bursa on both sides reveals no tenderness. **Anterior flexion of lumbar spine is noted to be 50 degrees (ROM range 0-50 degrees).** Anterior lumbar flexion does not cause pain. **Extension of lumbar spine is noted to be 25 degrees (ROM range 0-25 degrees).** There is no pain noted with lumbar extension. **Left lateral flexion of the lumbar spine is noted to be 20 degrees (ROM range 0-25 degrees).** Left lateral flexion causes no pain. **Right lateral flexion of the lumbar spine is noted to be 20 degrees (ROM range 0-25 degrees).** There is no pain noted with right lateral flexion.

Joints-Shoulder: On palpation, there is tenderness noted over the right anterior acromioclavicular joint. Right humerus/scapula is non-tender to palpation. No right shoulder swelling noted. There is no ecchymosis noted over the right shoulder. No right sided shoulder crepitus noted. No right shoulder deformity noted. There is no atrophy of the right shoulder noted. No right shoulder effusion noted. Right Shoulder ROM: Tested. Right shoulder labral test findings: Negative. Right scapula winging grade: 0. Right shoulder bicep test: Negative. Right shoulder impingement: Negative. Right shoulder O'Brien's test: Negative. Right shoulder popeye sign: Negative. Right shoulder stress test - joints: Normal. Right shoulder stress test - muscles: Normal. Reason right shoulder stress testing was not performed due to injury. **On palpation, there is tenderness noted over the left acromioclavicular joint.** Left humerus/scapula is nontender to palpation. No left shoulder swelling noted. There is no ecchymosis present over the left shoulder. No left sided shoulder crepitus noted. No left shoulder deformity noted. There is no atrophy of the left shoulder noted. No left shoulder effusion noted. Left Shoulder ROM: Tested. Left shoulder labral test findings: Negative. Left scapular winging grade: 0. Left shoulder bicep test: Negative. Left shoulder impingement test: Negative. Left shoulder O'Brien's test: Negative. Left shoulder popeye sign: Negative. Left shoulder stress test - joints: Normal. Left shoulder stress test - muscles: Normal. Reason left shoulder stress testing was not performed due to injury.

Joints- Hips/ SI Joint: Yeoman's Test: Negative right, negative left. Patrick's Test: Negative right, negative left. Lumbar spine is noted to be stable. No pelvic diastasis noted.

Joints-Knee: Right knee is non-tender to palpation. **There is tenderness noted in the diffuse pattern on the anterior region of the right knee.** There is no swelling noted in the right knee region. There is no ecchymosis noted on the right knee. No right knee effusion noted. Right knee ROM was tested. Right knee compartment testing is performed. Right knee patellofemoral exam has normal findings. Right Knee Ligament Testing: Normal findings. There is no ligament pain noted in the right knee. Right knee exam observation: consistent with symptoms. Left knee is non-tender to palpation. Tenderness is present in the diffuse pattern anteriorly of the left knee. There is no swelling noted in the left knee region. There is no ecchymosis noted on the left knee. Left knee effusion is absent. Left knee ROM was tested. Left knee compartment testing is performed. Left knee patellofemoral exam has normal findings. Left Knee Ligament testing: Normal findings. There is no ligament pain noted in the left knee. Left Knee Exam Observation: consistent with symptoms.

Joints- Ankles: The right ankle is without crepitus. **Right ankle is tender to palpation.** There is no right ankle joint effusion noted. The right ankle joint is noted to be stable. ROM is normal in the right ankle. The left ankle is without crepitus. **Left ankle is tender to palpation.** There is no left ankle joint effusion noted. The left ankle joint is stable. ROM is normal in the left ankle.

Pain Management

- Physical Therapy Prescription

Outcomes Assessment:

Plan

Naprosyn 500mg every 12 hour

Rx Prescribed: Lidocaine 5% ointment- Topical pain management for joints and large muscle groups. Apply 2-3 times daily to the affected area.

MRI was prescribed for Right Knee.

MRI was prescribed for Cervical Spine.

MRI was prescribed for Lumbar Spine.

Physical Therapy 3-4 times a week, Chiropractic and Acupuncture.

Procedure

CPT Codes:

Name	Code	Units
Office O/p New Low 30 Min	99203	1.00
Prolong Service W/o Contact	99358	1.00

Prescription

lidocaine 5 % topical ointment Apply 2-3 times per day on affected area for 30 Days , Prescribe 250 Gram
Naprosyn 500 mg tablet 1 Tablet Every 12 Hours PRN for 30 Days , Prescribe 60 Tablet

Follow up: -

E&M Time Factor (Min): 30-44

E&M Notes: Outcome assessment and patient chart was reviewed by Jordan Fersel M.D. on 12-24-2025

PATIENT DEMOGRAPHIC FORM 01/27/2026

OTERO, DESTINY

DOB: 07/24/1993

Cell Phone: 929-420-7722

Sex: Female

Home phone:

DOA: 11/03/2025

Social Security Number:

Case type: No Fault

Address: 24 METROPOLITAN OVAL MF, Bronx, NY, 10462

Primary Insurance: STATE FARM INS

Address: PO BOX 106170, Atlanta, GA, 30348

Claim Number: 32-93N9-25D

Policy Number: 3354955D0832D

Policy Holder: NUNEZ, RADDY

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: STRATFORD LAW GROUP PLLC

Address: 69 STRAFORD ROAD SUITE 1B, Brooklyn, NY, 11218

Phone number: 718-715-1600

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office: 2354 Chiropractic PC

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

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

Claim Number: _____

I, Destiny Otero ("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 11/3/25, 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.

Destiny Otero
(Print name of Patient)

Destiny Otero
(Signature of Patient)

01/27/26
(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)

01/27/26
(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: Wesley Olt Date: 11/27/26

Consent To X-Ray:

A Minor I am a parent or legal guardian of De
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: Wesley Olt 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: Wesley Olt Date: 11/27/26

Jordan Fersel MD PC

2354 Westchester Avenue, Bronx NY 10462
 Phone No.: 718 684-4535 x FAX: 718 684-4534 x
 drmchiro2354@gmail.com

PROGRESS NOTE

Patient First Name:	Patient Last Name:	Date of Birth:	Sex:
Destiny	Otero	07-24-1993	Female
Patient Address:		SSN:	
24 Metropolitan Oval, MF, Bronx NY 10462			
Attending Provider:	Referring Provider:	Visit Date:	Chart No.:
Jordan Fersel, M.D.		11-10-2025	SCL13005
Insurance Name:	Insurance Subscriber's ID:	Date of Injury:	Claim Id:
STATE FARM MUTUAL AUTOMOBILE INSURANCE CO	3354955D0832D	11-03-2025	32-93N9-25D
Appointment Location:	Appointment Location Address:	Encounter Type:	
Jordan Fersel MD PC	2354 Westchester Avenue, Bronx NY 10462	New Patient - Auto-Accident	

Chief Complaint: Cervical Spine Pain, Lumbar Spine Pain, Shoulder Pain, Hip Pain, Thoracic Pain, Elbow Pain

Motor Vehicle Accident

Destiny Otero is a 32 year old female who was involved in an accident on 11-03-2025. She At the time of accident patient was wearing seatbelt. Patient was a front seat passenger. Patient was in the car. One other person was in the vehicle. she suffered an impact to the right side of the vehicle. side swiped another vehicle she also suffered loss of consciousness for < 1 hour.

This was the first car accident of the patient. She was admitted to the ER. In the ER, a physical exam was done. was then sent home

Patient does not have history of back problems in the past. There was moderate damage to the car.

Cervical Spine Pain

Patient reported pain is bilateral. The patient describes her pain as constant. Patient says, at its worse her pain is 7/10. Right now she describes her pain as 7/10 on a pain scale of 0-10.

Lumbar Spine Pain

Patient reported pain is bilateral. The patient describes her pain as constant. Patient says, at its worse her pain is 7/10. Right now she describes her pain as 7/10 on a pain scale of 0-10. The pain is made worse by standing a long time.

Shoulder Pain

Patient reported pain is on right side. The patient describes her pain as frequent. Patient says, at its worse her

pain is 7/10. Right now she describes her pain as 7/10 on a pain scale of 0-10.

Hip Pain

Patient reported pain is on right side. The patient describes her pain as frequent. Patient says, at its worse her pain is 7/10. Right now she describes her pain as 6/10 on a pain scale of 0-10.

Thoracic Pain

Patient reported pain is bilateral. The patient describes her pain as frequent. Patient says, at its worse her pain is 7/10. Right now she describes her pain as 6/10 on a pain scale of 0-10.

Elbow Pain

Patient reported pain is on right side. The patient describes her pain as intermittent. The pain is numbing and pins and needle . **The pain radiates to the right fingers.** Patient says, at its worse her pain is 7/10. Right now she describes her pain as 6/10 on a pain scale of 0-10.

Past Medical History

No Known Past Medical History

Surgical History

Gyn surgery

Allergy

No Known Drug Allergies.

Social History

Use of Drugs/Alcohol/Tobacco: Patient states that she never drinks any alcohol. Never smoker

Review of Systems

Constitutional Symptoms: Patients appears normal. Denies fever, fatigue, chills, hot flashes, night sweats and weight loss.

Respiratory: Denies trouble breathing and shortness of breath.

Musculoskeletal: Reports **neck pain, shoulder pain, back pain and joint pain.**

Integumentary: Denies itching, rashes and boils.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. Patient has good hygiene.

Cervical Spine Exam: Inspection reveals normal curvature of the cervical spine. The cervical spine is supple.

Palpation of the cervical facet reveals pain in c3 - c7 region on both the sides and tenderness. Cervical spine is noted to be stable. Anterior flexion is noted to be 50 degrees (ROM range 0-50 degrees). **No pain noted with anterior neck flexion.** Extension of cervical spine noted to be 60 degrees (ROM range 0-60 degrees). **There is pain noted with extension of cervical spine.** Left lateral rotation noted to be 80 degrees (ROM range 0-80 degrees). There is no pain noted with left lateral rotation of C-spine. Left lateral flexion noted to be 45 degrees (ROM range 0-45 degrees). No pain noted with left lateral flexion of C-spine. **Right lateral rotation of the C-spine is noted to be 75 degrees (ROM range 0-80 degrees). There is pain noted with right lateral rotation. Right lateral flexion of the C-spine is noted to be 40 degrees (ROM range 0-45 degrees). There is pain noted with right lateral flexion.** There are no palpable trigger points in the muscles of the head and neck.

Thoracic Spine: There is no evidence of atrophy or asymmetry noted in the thoracic spine. **There is tenderness noted at facet joint lines.** Range of motion of the thoracic spine is normal with both flexion and extension without pain. There is evidence of crepitation, laxity or instability noted in the thoracic spine. Hyperextension of thoracic spine does not cause increased pain.

Lumbar Spine: Inspection of the lumbar spine reveals no scoliosis. **Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region.** There is no pain noted over the lumbar intervertebral spaces (discs) on palpation. **Palpation of the bilateral sacroiliac joint area reveals right sided pain and no left sided pain.** Palpation of the greater trochanteric bursa on both sides reveals no tenderness. **Anterior flexion of lumbar spine is noted to be 50 degrees (ROM range 0-50 degrees).** Anterior lumbar flexion causes pain. **Extension of lumbar spine is noted to be 20 degrees (ROM range 0-25 degrees).** There is pain noted with lumbar extension. Left lateral flexion of the lumbar spine is noted to be 25 degrees (ROM range 0-25 degrees). Left lateral flexion causes no pain. **Right lateral flexion of the lumbar spine is noted to be 15 degrees (ROM range 0-25 degrees).** There is pain noted with right lateral flexion.

Joints-Shoulder: Right shoulder is non-tender to palpation. **Right humerus/scapula area is tender to palpation which includes scapula.** No right shoulder swelling noted. There is no ecchymosis noted over the right shoulder. No right sided shoulder crepitus noted. No right shoulder deformity noted. There is no atrophy of the right shoulder noted. No right shoulder effusion noted. Right Shoulder ROM: Tested. Right Shoulder ROM Details: decreased. Right shoulder labral test findings: Negative. Right scapula winging grade: 0. Right shoulder bicep test: Negative. Right shoulder impingement: Negative. Right shoulder O'brien's test: Negative. Right shoulder popeye sign: Negative. Right shoulder stress test - joints: Normal. Right shoulder stress test - muscles: Normal. Reason right shoulder stress testing was not performed due to injury. Left shoulder is non-tender to palpation. Left humerus/scapula is nontender to palpation. No left shoulder swelling noted. There is no ecchymosis present over the left shoulder. No left sided shoulder crepitus noted. No left shoulder deformity noted. There is no atrophy of the left shoulder noted. No left shoulder effusion noted. Left Shoulder ROM: Tested. Left shoulder labral test findings: Negative. Left scapular winging grade: 0. Left shoulder bicep test: Negative. Left shoulder impingement test: Negative. Left shoulder O'brien's test: Negative. Left shoulder popeye sign: Negative. Left shoulder stress test - joints: Normal. Left shoulder stress test - muscles: Normal. Reason left shoulder stress testing was not performed due to injury.

Joints- Hips/ SI Joint: Yeoman's Test: Negative right, negative left. Patrick's Test: Positive right, negative left. Lumbar spine is noted to be stable. No pelvic diastasis noted.

Peripheral nerve exam: Head: Occipital nerve: right side. Greater and lesser

Peripheral Nerve Exam: Upper Extremities: Suprascapular nerve: right side.

Peripheral Nerve Exam: Elbow: Ulnar Nerve: right side.

Peripheral Nerve Exam: Lower Extremities: Lateral Femoral Cutaneous Nerve: right side.

Pain Management

- Disability Letter
- Physical Therapy Prescription

Outcomes Assessment:

Assessment and Plan

ICD: Cervical sprain (S13.9XXA)

ICD: Lumbar sprain (S33.5XXA)

ICD: Sprain, thoracic (S23.9XXA)

ICD: Sprain of shoulder, right (S43.401A)
ICD: Sprain of right hip (S73.101A)
ICD: Sprain of elbow, right (S53.401A)
ICD: Occipital neuralgia of right side (M54.81)
ICD: Sacroiliitis (M46.1)

Assessment

Needs R ONB, R suprascapular NB, R Ulnar NB, R LFC NB

Plan

Rx Prescribed: Lidocaine 5% ointment- Topical pain management for joints and large muscle groups. Apply 2-3 times daily to the affected area.

Rx Prescribed: Tizanidine 4mg- Oral muscle relaxant for involuntary contractions and muscle spasms.

MRI was prescribed for Cervical Spine.

MRI was prescribed for Lumbar Spine.

MRI was prescribed for Right Shoulder.

Physical Therapy 3-4 times a week, Chiropractic and Acupuncture.

Procedure

CPT Codes:

Name	Code	Units
Office O/p New Low 30 Min	99203	1.00

Prescription

lidocaine 5 % topical ointment Apply 2-3 times per day on affected area for 30 Days , Prescribe 250 Gram
tizanidine 4 mg tablet 1 Tablet At Bedtime for 30 Days , Prescribe 30 Tablet, Refills 1

Follow up: 4 Weeks

E&M Time Factor (Min): 30-44

E&M Notes: Outcome assessment was reviewed by Jordan Fersel M.D. on 11-12-25



Jordan Fersel, M.D.

NPI#: 1881685519

This has been electronically signed by Jordan Fersel, M.D. on 11-10-2025.