

13 patients
 Extremities 1955

Southern
 Blind

DATE: 2/11/28

X-RAY LIST

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 13

NAME:	NOTE:	
1. Ladson Storm - etc		
2. Guivel Victor - etc		
3. Ramirez Aranda - etc		
4. Cherry Frank - etc		
5. [REDACTED]		
6. pope Ramel - etc		
7. Samba Jacob - etc		
8. Wilson Robert - etc		
9. [REDACTED]		
10. Figueiroa Mengler - etc		
11. Paulino Angeles - etc		
12. Paulino Aranda - etc		
13. Peraltas Jose - etc		
14. Mendes Mercedes - etc		
15. Fraguada Jose - etc		
16.		
17.		
18.		
19.		
20.		

2/5/2026

(01373)-RAMIREZ PAULINO ANEUDY J

Date of Birth - 3/23/1983 Sex - Male Marital Status - Single

Address: 1983 SOUTHERN BLVD APT 2, The Bronx, NY, 10460
Phone #: (929) 783-0681

Social Security# - 781-66-4801

Employer or Company Name:

Address:
Emergency Name:
Work Phone #:

Date of Accident - 2/4/2026
Time/Place Accident -
Date of Visit -
Condition Related to : Auto Accident

Insurance Company : PROGRESIVE
Address:

Phone: Fax:

Claim# -
Policy Effective Date -
Policy# -
Policy holder -
WCB# -
Carrier case # -

Attorney - Firm Name -
Attorney Address -
Attorney Phone - Fax - Contact Person -

Other Insurance -
Medicare -



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: Ramirez Paulino, Aneudy
 Date of Birth: 03/23/1983
 Date of Accident: 02/04/2006
 Date of Service: 02/05/2006

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 43 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: 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, Aniel Rom ("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.

(Print name of Patient)

Aniel Rom
(Signature of Patient)

02/11/2026
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

02/11/2026
(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: _____

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: _____

2/5/2026

(01374)-SURIEL ROSARIO VICTOR

Date of Birth - 8/6/1969 Sex - Male Marital Status - Single

Address: 1002 CLLEGE AVE APT 1,The Bronx,NY,10456
Phone #: (646) 305-2384

Social Security# - 803-65-2538

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 2/4/2026

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : PROGRESSIVE

Address:

Phone: Fax:

Claim# -

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - Firm Name -

Attorney Address -

Attorney Phone - Fax -

Contact Person -

Other Insurance -

Medicare -



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: Suriel Rosario, Victor

Date of Birth: 08/06/1969

Date of Accident: 02/04/2026

Date of Service: 02/05/2026

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 56 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: 198 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: _____

Victor Sorvilic, Jr.
(Print patient's name)

Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS, ("Assignee")
(Print hospital or health care provider name)

all rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

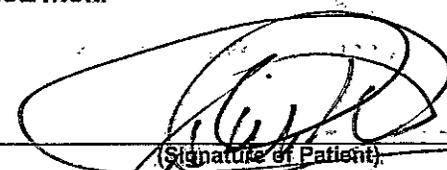
The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any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

to the contrary.

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

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

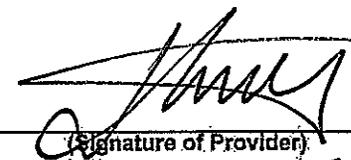
(Print name of Patient)


(Signature of Patient)

02/11/2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)


(Signature of Provider)

02/11/2026
(Date of signature)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301
(Address of Provider)

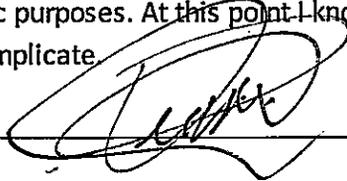
DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301
Tel: (570) 243-1888

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: _____

2/11/25

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: _____

(01261)-LADSON STORM O

Date of Birth - 9/8/1987 Sex - Male Marital Status - Single

Address: 1230 WEBSTER AVE, The Bronx; NY, 10456
Phone #: (347) 572-1018

Social Security# - XXX-XX-XX

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 11/26/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 8827899050000002

Claim Address - GEICO NY PIP

PO Box 9506

Fredericksburg, VA 22403-9506

NF-2 - Yes Sending Date - 12/24/2025

Policy Effective Date -

Policy# -

Policy holder -

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: Ladson, Storm

Date of Birth: 09/08/1987

Date of Accident: 11/26/2025

Date of Service: 12/02/2025

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

PRESENT COMPLAINTS:

The patient is a 38 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: 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, Storm Ladson ("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.

Storm Ladson
(Print name of Patient)

SL
(Signature of Patient)

(Address of Patient)

02/11/2026
(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)

02/11/2026
(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: Sh Date: 02/11/2026

Consent To X-Ray:

A Minor I am a parent or legal guardian of _____
who is a minor, _____ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this 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: _____

(01282)-PERALTA JOSE A

Date of Birth - 8/5/1976 Sex - Male Marital Status - Single

Address: 1115 WOODYCREST AVE APT BB, The Bronx, NY, 10452
Phone #: (551) 342-0076

Social Security# - XXX-XX-XXXX

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 : Foremost Insurance Co.

Address: 8558223139

Phone: Fax: 8558223139

Claim# - 26982534946

Claim Address - P.O.BOX 2450

GRAND RAPIDS, MICHIGAN 49501-2450

NF-2 - Yes Sending Date - 01/16/2026

Policy Effective Date -

Policy# -

Policy holder - PASCAL ESTEVEZ, FREDDY

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: Peralta, Jose

Date of Birth: 08/05/1976

Date of Accident: 12/19/2025

Date of Service: 12/23/2025

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 49 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: 185 Lbs.,

HEENT: Normal

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

Lymph nodes: The cervical, auxillary, 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, JOSE PERALTA ("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.

JOSE
(Print name of Patient)

Jose Peralta
(Signature of Patient)

(Address of Patient)

02/11/2026
(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)

02/11/2026
(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: JOSE PERALTA Date: _____

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: _____

(01333)-MENDEZ MERCEDES

Date of Birth - 9/26/1966 Sex - Female Marital Status - Single

Address: 1139 NELSON AVE #4C, The Bronx, NY, 10452
Phone #: (347) 403-3484

Social Security# - 082-80-7870

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 : CURE AUTO INSURANCE
Address:

Phone: Fax:

Claim# - CLM600069922
Claim Address - 214 CARNEGIE CENTER DRIVE
PRINCETON NEW JERSEY 08540
NF-2 - Yes Sending Date - 02/06/2026
Policy Effective Date -
Policy# - PANJ168896
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: mendez, mercedes

Date of Birth: 09/26/1966

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 X 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: 5-2", 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: _____

MERCEDES MENDOZA ("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.

MERCEDES MENDOZA
(Print name of Patient)

MERCEDES MENDOZA
(Signature of Patient)

02/11/2026
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

02/11/2026
(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: Mercedes Mercedes Date: 2/11/2026

Consent To X-Ray:

A Minor I am a parent or legal guardian of _____
who is a minor, _____ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this 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: Mercedes Mercedes Date: 2/11/2026

(01233)-FRAGUADA JOSE M

Date of Birth - 10/12/1980 Sex - Male Marital Status - Married

Address: 1510 ROSEDALE AVE, The Bronx, NY, 10460

Phone #: (646) 377-3453

Social Security# - 118-64-3951

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 11/9/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 8756839020000006

Claim Address - GEICO NY PIP

PO Box 9506

Fredericksburg, VA 22403-9506

NF-2 - Yes Sending Date - 12/09/2025

Policy Adjuster - Kyle Anderson

Policy Effective Date -

Policy# - 6100304259

Policy holder - FRAGUADA, JOSE

WCB# -

Carrier case # -

To Attorney - SANDERS LAW Firm Name - SANDERS LAW

Attorney Address - 1019 AVE P SUITE 201 BROOKLYN, NY 11223

Attorney Phone - 718-874-8869 Fax - 718-928-6886

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: Fraguada, Jose
 Date of Birth: 10/12/1980
 Date of Accident: 11/09/2025
 Date of Service: 11/18/2025

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 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: 6-1", Weight: 219 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, Jose Fraguada, ("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.

Jose Fraguada
(Print name of Patient)

Jose M Fraguada Jr
(Signature of Patient)

02/11/2026
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

02/11/2026
(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: Jose M. Fernandez Jr. Date: 2.11.26

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: _____

(01243)-CHERY FRANTO

Date of Birth - 4/3/1984 Sex - Male Marital Status - Single

Address: 22 E 119TH ST 420,New York,NY,10035
Phone #: (929) 274-9696

Social Security# - 592-26-0336

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 11/12/2025

Time/Place Accident - MADISON AVE,NEW YORK,NEW YORK

Policy Report - Yes

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 0684270450000009

Claim Address - P.O.BOX 9507

FREDERICKSBURG,VA 22403

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

Policy Effective Date -

Policy# -

Policy holder - SCOTT MOORE

WCB# -

Carrier case # -

Attorney - Law Office of Barry Richard Feldman Firm Name - Law Office of Barry Richard Feldman

Attorney Address - 26 Court St, Brooklyn, NY 11242

Attorney Phone - (347) 702-4867 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: Chery, Franto
 Date of Birth: 04/03/1984
 Date of Accident: 11/12/2025
 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 _____ hospital / Urgent

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

Pedestrian

PRESENT COMPLAINTS:

The patient is a 41 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: 167 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, Franco Cheryl, ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights, privileges and remedies to payment for health care services provided by assignee to which I am
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

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

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

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

Franco Cheryl
(Print name of Patient)

[Signature]
(Signature of Patient)

02/11/2026
(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)

02/11/2026
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

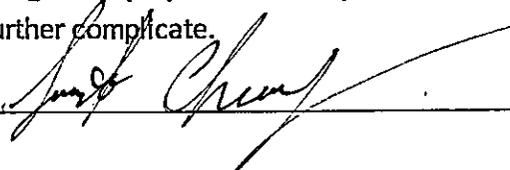
EAST STROUDSBURG PA 18301

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:  Date: _____

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: _____

(01366)-POPE RAMEL S

Date of Birth - 8/15/2002 Sex - Male Marital Status - Single

Address: 600 BERGEN AVE APT 1208, The Bronx, NY, 10455
Phone #: (929) 219-9201

Social Security# - 077-92-5126

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 1/29/2026

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : Travelers Auto Insurance

Address:

Phone: Fax:

Claim# - FRD0959

Claim Address - ONE TOWER SQUARE
HARTFORD, CT 06183

Policy Effective Date -

Policy# -

Policy holder -

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: Pope, Ramei
 Date of Birth: 08/15/2002
 Date of Accident: 01/29/2026
 Date of Service: 02/03/2026

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 23 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 (Rt) hand

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: 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, Ramel Pope, ("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.

Ramel Pope
(Print name of Patient)

Ramel Pope
(Signature of Patient)

600 bergen ave bronx
NY, 10455
(Address of Patient)

02/11/2026
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

02/11/2026
(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: Rama Pope Date: _____

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: _____

(01358)-SAMBA JACOB B

Date of Birth - 7/14/1975 Sex - Male Marital Status - Single

Address: 3330 BAYCHESTER, The Bronx, NY, 10475
Phone #: (347) 567-0331

Social Security# - 077-94-3253

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 1/26/2026

Time/Place Accident - CROSS BX EXPWY & GUNHILL ROAD CROSSING

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# -

Claim Address - ONE GEICO PLAZA
WASHINGTON, DC 20076-0001

Policy Effective Date - 8/6/2025

Policy# - 4449922758

Policy holder - SAMBA, JACOB

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: Samba, Jacob

Date of Birth: 07/14/1975

Date of Accident: 01/26/2026

Date of Service: 01/29/2026

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 50 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 Aminni

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: 5-5", 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, JACOB SAMBA, ("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.

JACOB SAMBA
(Print name of Patient)

Jacob Samba
(Signature of Patient)

02/11/2026
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

02/11/2026
(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: Jawell Anderson Date: 02/11/2026

Consent To X-Ray:

A Minor I am a parent or legal guardian of _____
who is a minor, _____ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this 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: _____

(01360)-WILSON JR ROBERT L

Date of Birth - 4/8/1966 Sex - Male Marital Status - Single

Address: 1404 JESUP AVE #6K, The Bronx, NY, 10452
Phone #: (347) 794-4514

Social Security# - 098-56-7487

Employer or Company Name:

Address:
Emergency Name:
Work Phone #:

Date of Accident - 1/29/2026
Time/Place Accident - MCCOMBS & CROMWELL AVE
Date of Visit -
Condition Related to : Auto Accident

Insurance Company : PROGRESSIVE CASUALTY INSURANCE CO
Address:

Phone: Fax:

Claim# - 26-711049397
Claim Address - 300 NORTH COMMONS BLVD
MAYFIELD VILLAGE , OHIO 44143
Policy Effective Date -
Policy# - 63356311
Policy holder - WILSON, ANNETTE & WILSON, KATHLEEN
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: Wilson Jr, Robert

Date of Birth: 04/08/1966

Date of Accident: 01/29/2026

Date of Service: 02/03/2026

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 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 Regular

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: 5-7 ", Weight: 135 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: _____

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

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

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

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

Robert Wilson
(Print name of Patient)

Robert Wilson
(Signature of Patient)

02/11/2026
(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)

02/11/2026
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC

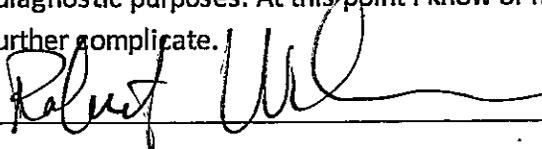
**3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301**

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:  Date: _____

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: _____

(01371)-FIGUEROA MENGLYS

Date of Birth - 6/9/1982 Sex - Female Marital Status - Single

Address: 2312 LORING PL, The Bronx, NY, 10468
Phone #: (347) 784-4671

Social Security# - 597-50-5902

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 1/20/2026

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : PROGRESIVE

Address:

Phone: Fax:

Claim# -

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - Firm Name -

Attorney Address -

Attorney Phone - Fax -

Contact Person -

Other Insurance -

Medicare -



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: Figueroa, manglys
 Date of Birth: 06/09/1988
 Date of Accident: 01/20/2006
 Date of Service: 02/05/2006

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 Mount Sinai hospital / Urgent

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

PRESENT COMPLAINTS:

The patient is a 43 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 (R) wrist

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 Penicillin
 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: 5-1", Weight: 136 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, mendysfigueroa, ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights, privileges and remedies to payment for health care services provided by assignee to which I am
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

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

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

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

mendysfigueroa
(Print name of Patient)

[Signature]
(Signature of Patient)

02/11/2026
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

02/11/2026
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

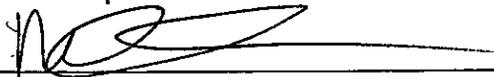
EAST STROUDSBURG PA 18301

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: 02-11-26

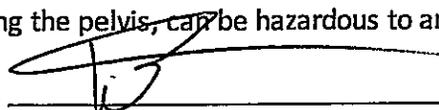
Consent To X-Ray:

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: 02-11-26

(01274)-PAULINO ANGEL A

Date of Birth - 12/14/1990 Sex - Male Marital Status - Single

Address: 268 REYNOLDS AVE, The Bronx, NY, 10465
Phone #: (917) 744-6734

Social Security# - 070-78-4577

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 12/7/2025

Time/Place Accident -

Date of Visit -

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 0607434470101022

Claim Address - GEICO NY PIP

PO Box 9506

Fredericksburg, VA 22403-9506

NF-2 - Yes Sending Date - 01/05/2026

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

To Attorney - SANDERS LAW Firm Name - SANDERS LAW

Attorney Address - 1019 AVE P SUITE 201 BROOKLYN, NY 11223

Attorney Phone - 718-874-8869 Fax - 718-928-6886

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: Paulino, Angel
 Date of Birth: 12/14/1990
 Date of Accident: 12/07/2025
 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 Acorn hospital / Urgent
 Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 35 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 (R) Hand

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: 165 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, Angel Paulino, ("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 12-07-2025, 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 FRAUD ANY INSURANCE COMPANY OR OTHER PERSON
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Angel Paulino
(Print name of Patient)

[Signature]
(Signature of Patient)

268 Reynolds Ave

02/11/2026
(Date of signature)

Bronx, NY 10465
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

02/11/2026
(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: 02-11-2026

Consent To X-Ray:

A Minor I am a parent or legal guardian of _____
who is a minor, _____ years of age. I hereby authorize the performance of diagnostic x-rays of
said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this 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: _____

(01275)-PAULINO AMANDA M

Date of Birth - 8/6/1992 Sex - Female Marital Status - Single

Address: 268 REYNOLDS AVE, The Bronx, NY, 10465
Phone #: (917) 558-7040

Social Security# - 066-84-5319

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 12/7/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 0607434470101022

Claim Address - GEICO NY PIP

PO Box 9506

Fredericksburg, VA 22403-9506

NF-2 - Yes Sending Date - 01/05/2026

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - SANDERS LAW Firm Name - SANDERS LAW

Attorney Address - 1019 AVE P SUITE 201 BROOKLYN, NY 11223

Attorney Phone - 718-874-8869 Fax - 718-928-6886

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: Paulino, Amanda
 Date of Birth: 08/06/1992
 Date of Accident: 12/07/2025
 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 Feuch hospital / Urgent
 Due to the accident the patient is working / not working in regular job.

PRESENT COMPLAINTS:

The patient is a 33 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: 5-5", Weight: 200 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, Amanda Paulino, ("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.

Amanda Paulino
(Print name of Patient)

[Signature]
(Signature of Patient)

208 Reynolds Ave
Bx NY 10465
(Address of Patient)

02/11/2026
(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)

02/11/2026
(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: _____  _____ Date: 2/11/24

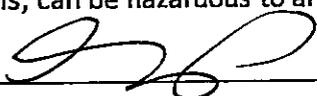
Consent To X-Ray:

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: 2/11/24