

2425 Earleherster
3/19/2025

- ① Vanders Dominique
- ② Gonzalez ELSG
- ③ Lestyné Jonathan
- ④ Taylor Garfield
- ⑤ Thompson Berest
- ⑥ Sheppard Jazmine
- ⑦ Ortheyg Karim S
- ⑧ Ortheyg Manuel
- ⑨ Razo Miguel
- ⑩ Matty Kenda

059

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301-0000
(201) 952-6420
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: ELSA GONZALEZ
DATE OF BIRTH: 10/12/1952
ID/MRN: 20250319002
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 03/19/2025
HISTORY: M25.512-PAIN IN LEFT SHOULDER

SIGNIFICANT FINDINGS

LEFT SHOULDER X-Ray Complete 2 or more views:

TECHNIQUE: 2 views of the left shoulder.

COMPARISON: None.

FINDINGS:

Arthritic change gleno-humeral articulation.

Normal acromioclavicular joint.

Normal acromion.

Normal visualized scapula.

Normal humeral head with sclerosis at greater tuberosity (rotator cuff injury) and visualized proximal humerus appears normal.

There is no demonstrated soft tissue abnormality.

Normal visualized pulmonary apex.

IMPRESSION:

- 1. Normal humeral head with sclerosis at greater tuberosity (rotator cuff injury).
 - 2. Arthritic change gleno-humeral articulation.
 - 3. No acute fracture
-

Electronically Signed By: Dr. Abbas Chamsuddin M.D. 03/29/2025 1:21:55 EDT

Tech: Dynamic Mobile Xray Services LLC

03/19/2025

(01035)-Vandross Domonique S.

Date of Birth - 05/12/1990 Sex - Female Marital Status - Single

Address: 2770 Dewey Avenue #5C, Bronx, NY, 10465

Phone #: (347) 928-7519

Social Security# - - -0972

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 01/03/2025

Time/Place Accident -

Date of Visit - 01/15/2025

Condition Related to : Auto Accident

Insurance Company : Travelers Insurance Co.

Address: 100 Baylis Rd.

Melville, NY, 11747

Phone: 1800-252-4633 Fax:

Claim# - 12B7278

NF-2 - Yes Sending Date - 01/30/2025

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Other Insurance -

Medicare -

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

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

Claim Number: _____

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

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

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

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

Dominique S. Vendross
(Print name of Patient)

L. Johnson
(Signature of Patient)

3/19/2025
(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)

3/19/2025
(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: L. O. Stinson Date: 3/19/25

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: L. O. Stinson Date: 3/19/25

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301-0000
(201) 952-6420
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: DOMONIQUE VANDROSS
DATE OF BIRTH: 05/12/1990
ID/MRN: 20250319001
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 03/19/2025
HISTORY: M25.511-PAIN IN RIGHT SHOULDER

RIGHT SHOULDER X-Ray Complete 2 or more views:

Comparison: None
Findings:
No acute fracture or dislocation
No osseous lesion
Joint spaces are arthritic with joint space narrowing
Soft tissues are unremarkable
No radiopaque foreign bodies.

IMPRESSION:

No significant findings.

Electronically Signed By: Palam Annamalai, MD 03/29/2025 0:51:12 EDT

Tech: Dynamic Mobile Xray Services LLC



DYNAMIC
MOBILE XRAY SERVICES LLC

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

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

MOBILE EXAM ORDER FORM

PATIENT INFORMATION:

NAME Domonique Vandross STAT
 D.O.B. _____ SS# _____ MALE FEMALE
 PATIENT ADDRESS or FACILITY NAME 2770 Dewey Ave #5C ROOM # _____
 CITY Bronx STATE NY ZIP: 10465 PHONE _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID# _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID# _____

X-RAYS: (Mark what is needed)

CHEST AND ABDOMEN

- Abdominal KUB 1 View 74018
- Abdominal Flat & Upright 2 View 7402
- Chest 1 View 71045
- Chest AP / LAT 71046
- Ribs 2 View (R) (L) 71100
- Ribs UNILATERAL - PA Chest 3 View 71101
- Ribs BILATERAL - PA Chest 4 View 71111

HEAD AND NECK

- Skull 70250
- Facial Bones 3 View 70150
- Orbits 4 View 70200
- Nasal Bones 3 View 70160
- Mandible (R) (L) 70100
- Sinuses 70210

UPPER EXTREMITIES

- Clavicle 2 View (R) (L) 73008
- Scapula 2 View (R) (L) 73010
- Shoulder 2 View (R) (L) 73030
- Humerus 2 View (R) (L) 73060
- Elbow 3 View (R) (L) 73080
- Forearm 2 View (R) (L) 73098
- Wrist 3 View (R) (L) 73110
- Hand 3 View (R) (L) 73130
- Fingers 2 View (R) (L) 73140

SPINE AND PELVIS

- Cervical Spine AP / LAT 72040
- Thoracic Spine 3 View 72072
- Lumbar Spine 2-3 View 72100
- Pelvis 1-2 View 72170
- Sacrum Occcyx 72220

Reason for study: _____

UPPER EXTREMITIES

- HIP BILATERAL 4 View 73520
- HIP AP / LAT (R) (L) 73501
- Femur 2 View (R) (L) 73550
- Knee 1-2 View (R) (L) 73560
- Knee 3 View (R) (L) 73562
- Tibia / Fibula 2 View (R) (L) 73590
- Ankle 3 View (R) (L) 73610
- Foot 3 View (R) (L) 73630
- Heel 2 View (R) (L) 73650
- Toes 2 View (R) (L) 73660

Other: _____

Ultrasonounds: (Mark what is needed)

Vascular Studies (Rule out DVT)

- Venous Upper (Bilat) (R) (L) 93970/93971
- Venous Lower (Bilat) (R) (L) 93970/93971
- Arterial Upper (Bilat) (R) (L) 93930/93931
- Arterial Lower (Bilat) (R) (L) 93925/93928
- Arterial with Ankle Brachial Index (ABI) 93922

Abdomen

- Complete Abdominal 76770
- AORTA / AAA 76706
- Renal 76770
- Bladder 76857

Pelvic

- Pelvic 76858
- Pelvic Non-OB* 76856
- Testicular / Scrotum 76870
- Soft Tissue Groin 76882

Head and Neck

- Thyroid 76535
- Neck Soft Tissue 76536
- R Carotid Duplex Doppler 83880

Reason for study: _____

Breast

- Breast (Bilat) (R) (L) 76642/76641

Other: _____

* Abdominal Ultrasonounds require patient not eat or drink at least 8 Hours prior to exam.

** Pelvic Ultrasonounds require the patient to have a full urinary bladder.

CARDIAC STUDIES:

- EKG 93000
- Holter Monitor 24 HR 93228
- Echocardiogram 93308
- Pacemaker check 93293

REQUESTING PHYSICIAN:

NAME _____ NPI # _____ FAX # _____
 SIGNATURE [Signature] TODAY'S DATE 03/19/25

03/19/2025

(01027)-Gonzalez Elsa

Date of Birth - 10/12/1952 Sex - Female Marital Status - Single

Address: 1715 Randall Avenue #5E, Bronx, NY, 10473
Phone #: (347) 344-4722

Social Security# -

Employer or Company Name:

Address:
Emergency Name: 347-344-4722
Work Phone #:

Date of Accident - 12/21/2024
Time/Place Accident - Bronx River Pkwy North
Policy Report - Yes
Date of Visit - 12/26/2024
Condition Related to : Auto Accident

Insurance Company : State Farm Fire & Casualty Co.
Address:

Phone: 800-258-9884 Fax:

Claim# - 32-78325J
NF-2 - Yes Sending Date - 01/16/2025
Policy Effective Date -
Policy# -
Policy holder -
WCB# -
Carrier case # -
Other Insurance -
Medicare -

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

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

Claim Number: _____

Elsa Benzale ("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.

Elsa Benzale
(Print name of Patient)

Elsa Benzale
(Signature of Patient)

3/19/2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

3/19/2025
(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: Elsa Gonzalez Date: 3, 19, 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: Elsa Gonzalez Date: 3/19/25



DYNAMIC
MOBILE XRAY SERVICES LLC

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

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

MOBILE EXAM ORDER FORM

PATIENT INFORMATION:

NAME Elsa Gonzalez STAT STAT
 D.O.B. 10/12/1952 SS# _____ MALE FEMALE
 PATIENT ADDRESS or FACILITY NAME 1715 Randall Ave #5E ROOM# _____
 CITY BREX STATE NY ZIP 10473 PHONE _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID# _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID# _____

X-RAYS: (Mark what is needed)

CHEST AND ABDOMEN

- Abdominal KUB 1 View 74018
- Abdominal Flat & Upright 2 View 7402
- Chest 1 View 71045
- Chest AP / LAT 71046
- Ribs 2 View (R) (L) 71100
- Ribs UNILATERAL - PA Chest 3 View 71101
- Ribs BILATERAL - PA Chest 4 View 71111

HEAD AND NECK

- Skull 70250
- Facial Bones 3 View 70150
- Orbit 4 View 70200
- Nasal Bones 3 View 70160
- Mandible (R) (L) 70100
- Sinuses 70210

UPPER EXTREMITIES

- Clavicle 2 View (R) (L) 73000
- Scapula 2 View (R) (L) 73010
- Shoulder 2 View (R) (L) 73030
- Humerus 2 View (R) (L) 73060
- Elbow 3 View (R) (L) 73080
- Forearm 2 View (R) (L) 73090
- Wrist 3 View (R) (L) 73110
- Hand 3 View (R) (L) 73130
- Fingers 2 View (R) (L) 73140

SPINE AND PELVIS

- Cervical Spine AP / LAT 72040
- Thoracic Spine 3 View 72072
- Lumbar Spine 2-3 View 72100
- Pelvis 1-2 View 72170
- Sacrum 2 View 72220

Reason for study: _____

UPPER EXTREMITIES

- HIP BILATERAL 4 View 73520
- HIP AP / LAT (R) (L) 73501
- Femur 2 View (R) (L) 73550
- Knee 1-2 View (R) (L) 73560
- Knee 3 View (R) (L) 73562
- Tibia / Fibula 2 View (R) (L) 73590
- Ankle 3 View (R) (L) 73610
- Foot 3 View (R) (L) 73630
- Heel 2 View (R) (L) 73650
- Toes 2 View (R) (L) 73660

Other: _____

Ultrasonounds: (Mark what is needed)

Vascular Studies (Rule out DVT)

- Venous Upper (Bilat) (R) (L) 93970/93971
- Venous Lower (Bilat) (R) (L) 93970/93971
- Arterial Upper (Bilat) (R) (L) 93930/93931
- Arterial Lower (Bilat) (R) (L) 93925/93926
- Arterial with Ankle-Brachial Index (ABI) 93922

Abdomen

- Complete Abdominal* 76770
- AORTA / AAA 76706
- Renal 76770
- Bladder** 76857

Pelvic

- Pelvic** 76858
- Pelvic Non-OB** 76956
- Testicular / Scrotum 76870
- Soft Tissue Groin 76882

Head and Neck

- Thyroid 76536
- Neck Soft tissue 76536
- Carotid Duplex Doppler 93860

Reason for study: _____

Breast

- Breast (Bilat) (R) (L) 76642/76641

Other: _____

* Abdominal Ultrasonounds require patient not eat or drink at least 6 hours prior to exam

** Pelvic Ultrasonounds require the patient to have a full urinary bladder.

CARDIAC STUDIES:

- EKG 93000
- Holter Monitor 24 HR 93228
- Echocardiogram 93306
- Pacemaker check 93293

REQUESTING PHYSICIAN:

NAME _____ NPI # 1295086186
 SIGNATURE RTZ TODAY'S DATE 03/19/25 FAX # _____

03/19/2025

(01043)-Lestyne Jonathan M.

Date of Birth - 10/03/1996 Sex - Male Marital Status - Single

Address: 2015 Newbold Ave #D24, Bronx, NY, 10462

Phone #: (917) 583-1014

Social Security# - -8590

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 01/15/2025

Time/Place Accident - E. Fordham Rd / Southern Blvd

Policy Report - Yes

Date of Visit - 01/27/2025

Condition Related to : Auto Accident

Insurance Company : Government Employees Insurance Co.

Address:

Phone: Fax:

Claim# - 8810672830000002

NF-2 - Yes Sending Date - 02/03/2025

Policy Adjuster - Michael Kresner 516-714-7628

Policy Effective Date -

Policy# - 6160052442

Policy holder - Lestyne, Tyrone, L

WCB# -

Carrier case # -

Other Insurance -

Medicare -

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301-0000
(201) 952-6420
dynamicmobilexrays@gmail.com

Radioogy Interpretation

PATIENT NAME: JONATHAN LESTYNE
DATE OF BIRTH: 10/03/1996
ID/MRN: 20250319004
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 03/19/2025
HISTORY: M25.512-PAIN IN LEFT SHOULDER

LEFT SHOULDER X-Ray Complete 2 or more views:

TECHNIQUE: AP /LAT views of the left shoulder.
COMPARISON: None.
FINDINGS:
Normal gleno-humeral articulation.
Normal acromioclavicular joint.
Normal acromion.
Normal humeral head and visualized proximal humerus.
Normal visualized scapula.
There is no demonstrated soft tissue abnormality.
Normal visualized pulmonary apex.

IMPRESSION:

1. Normal x-ray examination of the shoulder.
 2. No acute fracture
-

Electronically Signed By: Dr. Abbas Chamsuddin M.D. 03/29/2025 1:23:40 EDT

Tech: Dynamic Mobile Xray Services LLC

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

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

Claim Number: _____

(Jonathan Lestyre Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS ("Assignee")
(Print patient's name) (Print hospital or health care provider name)

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

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

to the contrary.

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

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

Jonathan Lestyre
(Print name of Patient)

[Signature]
(Signature of Patient)

3/19/2025
(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)

3/19/2025
(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: [Signature] Date: 03, 19, 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: _____



DYNAMIC
MOBILE XRAY SERVICES LLC

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

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

MOBILE EXAM ORDER FORM

PATIENT INFORMATION

NAME Jonathan Lestue STAT D.O.B. 10/3/96 SS# _____ MALE FEMALE
 PATIENT ADDRESS or FACILITY NAME _____ ROOM # _____
 CITY _____ STATE _____ ZIP _____ PHONE _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

X-RAYS (Mark what is needed)

CHEST AND ABDOMEN

- Abdominal KUB 1 View 74019
- Abdominal Flat & Upright 2 View 7402
- Chest 1 View 71045
- Chest AP / LAT 71046
- Ribs 2 View (R) (L) 71100
- Ribs UNILATERAL + PA Chest 3 View 71101
- Ribs BILATERAL + PA Chest 4 View 71111

HEAD AND NECK

- Skull 70250
- Facial Bones 3 View 70150
- Orbits 4 View 70200
- Nasal Bones 3 View 73169
- Mandible (R) (L) 76135
- Sinuses 76219

UPPER EXTREMITIES

- Clavicle 2 View (R) (L) 73000
- Scapula 2 View (R) (L) 73010
- Shoulder 2 View (R) (L) 73030
- Humerus 2 View (R) (L) 73080
- Elbow 3 View (R) (L) 73080
- Forearm 2 View (R) (L) 73090
- Wrist 3 View (R) (L) 73110
- Hand 3 View (R) (L) 73130
- Fingers 2 View (R) (L) 73140

SPINE AND PELVIS

- Cervical Spine AP / LAT 72040
- Thoracic Spine 3 View 72072
- Lumbar Spine 2-3 View 72100
- Pelvis 1-2 View 72170
- Sacrum Coccyx 72220

Reason for study: _____

UPPER EXTREMITIES

- HIP BILATERAL 4 View 73520
- HIP AP / LAT (R) (L) 73501
- Femur 2 View (R) (L) 73550
- Knee 1-2 View (R) (L) 73560
- Knee 3 View (R) (L) 73582
- Tibia / Fibula 2 View ... (R) (L) 73590
- Ankle 3 View (R) (L) 73610
- Foot 3 View (R) (L) 73630
- Heel 2 View (R) (L) 73650
- Toes 2 View (R) (L) 73680

Other : _____

Ultrasounds (Mark what is needed)

Vascular Studies (Rule out DVT)

- Venous Upper (Bilat) (R) ... (L)..... 93970/93971
- Venous Lower (Bilat) (R) ... (L)..... 93970/93971
- Arterial Upper (Bilat) (R) ... (L)..... 93930/93931
- Arterial Lower (Bilat) (R) ... (L)..... 93925/93926
- Arterial with Ankle-Brachial Index (ABI) 93922

Pelvic

- Pelvic ** 78858
- Pelvic Non-OB ** 78858
- Testicular / Scrotum 78870
- Soft Tissue Groin 78882

Breast

- Breast (Bilat) (R) (L) 78842/78841

Other _____

* Abdominal Ultrasounds require patient not eat or drink at least 6 Hours prior to exam

** Pelvic Ultrasounds require the patient to have a full urinary bladder.

Abdomen

- Complete Abdominal * 76770
- AORTA / AAA 76708
- Renal 76770
- Bladder ** 78857

Head and Neck

- Thyroid 78536
- Neck Soft tissue 78536
- Carotid Duplex Doppler 83880

Reason for study: _____

CARDIAC STUDIES

- EKG 83000
- Holter Monitor 24 HR 83228
- Echocardiogram 93308
- Pacemaker check 83293

REQUESTING PHYSICIAN

NAME ROBERT ROOK NPI # 1295026136 FAX # _____
 SIGNATURE [Signature] TODAY'S DATE ROBERT ROOK 03/19/25

03/19/2025

(01061)-Taylor Garfield Y.

Date of Birth - 09/26/1977 Sex - Male Marital Status - Single

Address: 4358 Richardson Avenue #3N, Bronx, NY, 10466
Phone #: (917) 504-2668

Social Security# - - -4906

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 02/26/2025

Time/Place Accident - Eastchester Rd / Mace Avenue

Policy Report - Yes

Date of Visit - 02/27/2025

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 8827488280000001

NF-2 - Yes Sending Date - 03/17/2025

Policy Effective Date -

Policy# - 6065-01-05-86

Policy holder - Taylor Garfield

WCB# -

Carrier case # -

Other Insurance -

Medicare -

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

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

Claim Number: _____

Garfield Taylor ("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 2/26/25, not withstanding any other agreement to the contrary.
(Print accident date)

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

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

Garfield Taylor
(Print name of Patient)

4358 Richardson Ave #305

Bk Nyc 10466
(Address of Patient)

M. Taylor
(Signature of Patient)

3/19/2025
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301
(Address of Provider)

[Signature]
(Signature of Provider)

3/19/2025
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

Parent Consent To X-Ray:

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

Signed: M. Joyal Date: 3/19/25

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: M. Joyal Date: 3/19/25

Females: Regarding Possibility of Pregnancy

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

Signed: M. Joyal Date: 3/19/25

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301-0000
(201) 952-6420
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: GARFIELD TAYLOR
DATE OF BIRTH: 09/26/1977
ID/MRN: 20250319005
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 03/19/2025
HISTORY: M25.511-PAIN IN RIGHT SHOULDER

RIGHT SHOULDER X-Ray Complete 2 or more views:

Comparison: None

FINDINGS:

Multiple views of the right shoulder show normal alignment at the gleno-humeral joint.
There are no acute fractures or dislocations.
The acromioclavicular joint and coracoclavicular spaces are intact.
The visualized scapula and clavicle are unremarkable.
There are no radiopaque foreign bodies.
No soft tissue swelling is seen.
If there is further concern, follow-up radiographs or MRI of the shoulder may be performed for complete assessment.

IMPRESSION:

No acute fracture or dislocation of right shoulder.

Electronically Signed By: Dr. Lan Vu M.D. 03/29/2025 1:33:37 EDT

Tech: Dynamic Mobile Xray Services LLC



DYNAMIC
MOBILE XRAY SERVICES LLC

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

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

MOBILE EXAM ORDER FORM

PATIENT INFORMATION:

NAME Garfield Taylor STAT D.O.B. 9/26/77 SS# _____ MALE FEMALE
 PATIENT ADDRESS or FACILITY NAME 4358 Richardson Ave #3N ROOM # _____
 CITY BRONX STATE NY ZIP 10460 PHONE 917-504-2668
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

X-RAYS: (Mark what is needed)

CHEST AND ABDOMEN

- Abdominal KUB 1 View 74018
- Abdominal Flat & Upright 2 View 7402
- Chest 1 View 71045
- Chest AP/LAT 71946
- Ribs 2 View (R) (L) 71100
- Ribs UNILATERAL - PA Chest 3 View 71101
- Ribs BILATERAL - PA Chest 4 View 71111

HEAD AND NECK

- Skull 70250
- Facial Bones 3 View 70150
- Orbitals 4 View 70200
- Nasal Bones 3 View 70160
- Mandible (R) (L) 70100
- Sinuses 70210

UPPER EXTREMITIES

- Clavicle 2 View (R) (L) 73000
- Scapula 2 View (R) (L) 73010
- Shoulder 2 View (R) (L) 73030
- Humerus 2 View (R) (L) 73060
- Elbow 3 View (R) (L) 73080
- Forearm 2 View (R) (L) 73090
- Wrist 3 View (R) (L) 73110
- Hand 3 View (R) (L) 73130
- Fingers 2 View (R) (L) 73140

SPINE AND PELVIS

- Cervical Spine AP/LAT 72040
- Thoracic Spine 3 View 72072
- Lumbar Spine 2-3 View 72100
- Pelvis 1-2 View 72170
- Sacrum Coccyx 72220

Reason for study: _____

UPPER EXTREMITIES

- HIP BILATERAL 4 View 73520
- HIP AP/LAT (R) (L) 73501
- Femur 2 View (R) (L) 73550
- Knee 1-2 View (R) (L) 73550
- Knee 3 View (R) (L) 73562
- Tibia / Fibula 2 View (R) (L) 73590
- Ankle 3 View (R) (L) 73610
- Foot 3 View (R) (L) 73630
- Heel 2 View (R) (L) 73650
- Toes 2 View (R) (L) 73660

Other: _____

Ultrasounds: (Mark what is needed)

Vascular Studies (Rule out DVT)

- Venous Upper (Bilat) (R) (L) 93970/93971
- Venous Lower (Bilat) (R) (L) 93970/93971
- Arterial Upper (Bilat) (R) (L) 93930/93931
- Arterial Lower (Bilat) (R) (L) 93925/93926
- Arterial with Ankle Brachial Index (ABI) 93922

Abdomen

- Complete Abdominal 76770
- AORTA / AAA 76706
- Renal 76770
- Bladder ** 76857

Pelvic

- Pelvic ** 76856
- Pelvic Non-OB ** 76856
- Testicular / Scrotum 76870
- Soft Tissue Grain 76882

Head and Neck

- Thyroid 76536
- Neck Soft Tissue 76536
- Carotid Duplex Doppler 83880

Reason for study: _____

Breast

- Breast (Bilat) (R) (L) 76642/76641

Other: _____

* Abdominal Ultrasounds require patient not eat or drink at least 8 hours prior to exam

** Pelvic Ultrasounds require the patient to have a full urinary bladder.

CARDIAC STUDIES:

- EKG 93000
- Holter Monitor 24 HR 93228
- Echocardiogram 93306
- Pacemaker check 93293

REQUESTING PHYSICIAN:

NAME _____ NPI # 1295026136 FAX # _____
 SIGNATURE [Signature] TODAY'S DATE 03/19/25

03/19/2025

(01044)-Thompson Berest A.

Date of Birth - 03/02/1985 Sex - Male Marital Status - Single

Address: 1537 E. Gun Hill Rd.,Bronx,NY,10469

Phone #: (929) 365-5161

Social Security# - - -8102

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 02/01/2025

Time/Place Accident - Arnow Avenue / Paulding Avenue

Policy Report - Yes

Date of Visit - 02/03/2025

Condition Related to : Auto Accident

Insurance Company : Integon National Insurance Company

Address: P.O.Box 22086

Burlington,NJ,27215

Phone: 518-431-6410 Fax:

Claim# - 250090593

NF-2 - Yes Sending Date - 02/25/2025

Policy Adjuster - 800-400-2901

Mr Rocco 908-842-1793

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Other Insurance -

Medicare -

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301-0000
(201) 952-6420
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: BEREST THOMPSON
DATE OF BIRTH: 03/02/1985
ID/MRN: 20250319006
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 03/19/2025
HISTORY: M25.511-PAIN IN RIGHT SHOULDER, M25.512-PAIN IN LEFT SHOULDER

LEFT SHOULDER X-Ray Complete 2 or more views:

Comparison: None

FINDINGS:

Multiple views of the left shoulder show normal alignment at the gleno-humeral joint.
There are no acute fractures or dislocations.
The acromioclavicular joint and coracoclavicular spaces are intact.
The visualized scapula and clavicle are unremarkable.
There are no radiopaque foreign bodies.
No soft tissue swelling is seen.
If there is further concern, follow-up radiographs or MRI of the shoulder may be performed for complete assessment.

IMPRESSION:

No acute fracture or dislocation of left shoulder.

RIGHT SHOULDER X-Ray Complete 2 or more views:

Comparison: None

FINDINGS:

Multiple views of the right shoulder show normal alignment at the gleno-humeral joint.
There are no acute fractures or dislocations.
The acromioclavicular joint and coracoclavicular spaces are intact.
The visualized scapula and clavicle are unremarkable.
There are no radiopaque foreign bodies.
No soft tissue swelling is seen.
If there is further concern, follow-up radiographs or MRI of the shoulder may be performed for complete assessment.

IMPRESSION:

No acute fracture or dislocation of right shoulder.

Electronically Signed By: Dr. Lan Vu M.D. 03/29/2025 1:37:22 EDT

Tech: Dynamic Mobile Xray Services LLC

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

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

Claim Number: _____

Berest Thompson ("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.

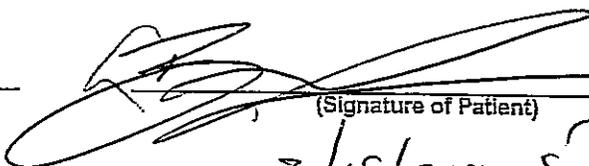
The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on 2/1/25, not withstanding any 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.

Berest Thompson
(Print name of Patient)

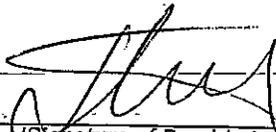

(Signature of Patient)

1537 F. Gun Hill rd

3/19/2025
(Date of signature)

By NY 10469
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)


(Signature of Provider)

3412 BLUESTONE LANE

3/19/2025
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

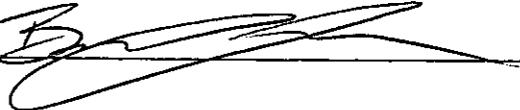
EAST STROUDSBURG PA 18301

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: 3.19.25

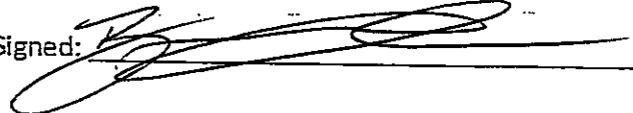
Consent To X-Ray:

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: 3/19/25

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: 3/19/25



DYNAMIC
MOBILE XRAY SERVICES LLC

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

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

MOBILE EXAM ORDER FORM

PATIENT INFORMATION:

NAME Berest Thompson STAT D.O.B. 3/2/85 SS# _____ MALE FEMALE
 PATIENT ADDRESS or FACILITY NAME 1537 E Gun Hill Rd ROOM # _____
 CITY Beox STATE N.Y. ZIP 10469 PHONE 929-365-5161
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

X-RAYS: (Mark what is needed)

CHEST AND ABDOMEN

- Abdominal KUB 1 View 74018
- Abdominal Flat & Upright 2 View 74022
- Chest 1 View 71045
- Chest AP / LAT 71046
- Ribs 2 View (R) (L) 71048
- Ribs UNILATERAL - PA Chest 3 View 71101
- Ribs BILATERAL - PA Chest 4 View 71111

HEAD AND NECK

- Skull 70250
- Facial Bones 3 View 70150
- Orbits 4 View 70200
- Nasal Bones 3 View 70160
- Mandible (R) (L) 70100
- Sinuses 70210

UPPER EXTREMITIES

- Clavicle 2 View (R) (L) 73000
- Scapula 2 View (R) (L) 73010
- Shoulder 2 View (R) (L) 73030
- Humerus 2 View (R) (L) 73060
- Elbow 3 View (R) (L) 73080
- Forearm 3 View (R) (L) 73090
- Wrist 3 View (R) (L) 73116
- Hand 3 View (R) (L) 73130
- Fingers 2 View (R) (L) 73140

SPINE AND PELVIS

- Cervical Spine AP / LAT 72040
- Thoracic Spine 3 View 72072
- Lumbar Spine 2-3 View 72100
- Pelvis 1-2 View 72170
- Sacrum Cecox 72220

Reason for study: _____

UPPER EXTREMITIES

- HIP BILATERAL 4 View 73520
- HIP AP / LAT (R) (L) 73501
- Femur 2 View (R) (L) 73560
- Knee 1-2 View (R) (L) 73550
- Knee 3 View (R) (L) 73562
- Tibia / Fibula 2 View (R) (L) 73590
- Ankle 3 View (R) (L) 73610
- Foot 3 View (R) (L) 73630
- Heel 2 View (R) (L) 73650
- Toes 2 View (R) (L) 73660

Other: _____

Ultrasounds: (Mark what is needed)

Vascular Studies (Rule-out DVT)

- Venous Upper (Bilat) (R) (L) 93570/93571
- Venous Lower (Bilat) (R) (L) 93970/93971
- Arterial Upper (Bilat) (R) (L) 93930/93931
- Arterial Lower (Bilat) (R) (L) 93925/93926
- Arterial with Ankle-Brachial Index (ABI) 93922

Abdomen

- Complete Abdominal 76770
- AORTA / AAA 76706
- Renal 76770
- Bladder ** 76857

Pelvic

- Pelvic ** 76858
- Pelvic Non-OB ** 76956
- Testicular / Scrotum 76870
- Soft Tissue Grain 76882

Head and Neck

- Thyroid 76536
- Neck Soft Tissue 76536
- RCaretic Duplex Doppler 93880

Reason for study: _____

Breast

- Breast (Bilat) (R) (L) 76642/76641

Other: _____

* Abdominal Ultrasounds require patient not eat or drink at least 6 Hours prior to exam

** Pelvic Ultrasounds require the patient to have a full urinary bladder.

CARDIAC STUDIES:

- EKG 93000
- Holter Monitor 24 HR 93228
- Echocardiogram 93306
- Pacemaker check 93293

REQUESTING PHYSICIAN:

NAME _____ NPI # 1295026136 FAX # _____
 SIGNATURE Robert Hook TODAY'S DATE _____

03/19/2025

(01058)-Sheppard Jazmin P.

Date of Birth - 07/20/1990 Sex - Female Marital Status - Single

Address: 308 Leaf Street #1, Tobyhanna, NY, 18466
Phone #: (845) 784-9082

Social Security# - - -2569

Employer or Company Name:

Address:
Emergency Name:
Work Phone #:

Date of Accident - 02/25/2025
Time/Place Accident -
Date of Visit - 02/27/2025
Condition Related to : Auto Accident

Insurance Company : Progressive Advanced Insurance Company
Address:

Phone: Fax:

Claim# - 25-838817922
NF-2 - Yes Sending Date - 03/17/2025
Policy Effective Date -
Policy# -
Policy holder -
WCB# -
Carrier case # -
Other Insurance -
Medicare -

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301-0000
(201) 952-6420
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: JAZMIN SHEPPARD
DATE OF BIRTH: 07/20/1990
ID/MRN: 20250319007
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 03/19/2025
HISTORY: M25.511-PAIN IN RIGHT SHOULDER, M25.562-PAIN IN LEFT KNEE

RIGHT SHOULDER X-Ray Complete 2 or more views:

Normal bone density is identified. No fracture or dislocation is seen. No acute findings identified.

IMPRESSION:

No fracture, dislocation or significant abnormality noted.

LEFT KNEE X-Ray - 1-2 view:

Normal bone density is identified. No fracture or dislocation is seen. No acute findings identified.

IMPRESSION:

No fracture, dislocation or significant abnormality noted.

Electronically Signed By: Dr. Robin Connolly M.D. 03/30/2025 20:20:53 EDT

Tech: Dynamic Mobile Xray Services LLC

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

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

Claim Number: _____

Jazmin sheppard ("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 2/25/25, 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.

Jazmin sheppard
(Print name of Patient)

308 Leaf St #1.

Tobfham NY 18466
(Address of Patient)

Jazmin sheppard
(Signature of Patient)

3/19/2025
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301
(Address of Provider)

[Signature]
(Signature of Provider)

3/19/2025
(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: Raymi Sheppard Date: 3/19/25

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: 3/19/25

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: Raymi Sheppard Date: 3/19/25



DYNAMIC
MOBILE XRAY SERVICES LLC

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

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

MOBILE EXAM ORDER FORM

PATIENT INFORMATION:

NAME Jazmin Sheppard STAT
D.O.B: 7/20/1990 SS# _____ MALE FEMALE
PATIENT ADDRESS or FACILITY NAME 308 Leaf St #1 ROOM # _____
CITY Towhanna STATE NY ZIP 18466 PHONE 845-784-9082
PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

X-RAYS: (Mark what is needed)

CHEST AND ABDOMEN

- Abdominal KUB 1 View 74016
- Abdominal Flat & Upright 2 View 7402
- Chest 1 View 71045
- Chest AP / LAT 71046
- Ribs 2 View (R) (L) 71100
- Ribs UNILATERAL - PA Chest 3 View 71101
- Ribs BILATERAL - PA Chest 4 View 7111

HEAD AND NECK

- Skull 70250
- Facial Bones 3 View 70150
- Orbit 4 View 70200
- Nasal Bones 3 View 70150
- Mandible (R) (L) 70100
- Sinuses 70210

UPPER EXTREMITIES

- Clavicle 2 View (R) (L) 73000
- Scapula 2 View (R) (L) 73010
- Shoulder 2 View (R) (L) 73030
- Humerus 2 View (R) (L) 73060
- Elbow 3 View (R) (L) 73080
- Forearm 2 View (R) (L) 73090
- Wrist 3 View (R) (L) 73110
- Hand 3 View (R) (L) 73130
- Fingers 2 View (R) (L) 73140

SPINE AND PELVIS

- Cervical Spine AP / LAT 72040
- Thoracic Spine 3 View 72072
- Lumbar Spine 2-3 View 72100
- Pelvis 1-2 View 72170
- Sacrum Coccyx 72220

UPPER EXTREMITIES

- HIP BILATERAL 4 View 73520
- HIP AP / LAT (R) (L) 73501
- Femur 2 View (R) (L) 73560
- Knee 1-2 View (R) (L) 73580
- Knee 3 View (R) (L) 73582
- Tibia / Fibula 2 View (R) (L) 73590
- Ankle 3 View (R) (L) 73610
- Foot 3 View (R) (L) 73630
- Heel 2 View (R) (L) 73650
- Toes 2 View (R) (L) 73660

Other: _____

Reason for study: _____

Ultrasounds: (Mark what is needed)

Vascular Studies (Rule-out DVT)

- Venous Upper (Bilat) (R) (L) 93570/93971
- Venous Lower (Bilat) (R) (L) 93970/93971
- Arterial Upper (Bilat) (R) (L) 93930/93931
- Arterial Lower (Bilat) (R) (L) 93925/93926
- Arterial with Ankle-Brachial Index (ABI) 93922

Abdomen

- Complete Abdominal * 76770
- AORTA / AAA 76705
- Renal 76770
- Bladder ** 76857

Pelvic

- Pelvic ** 76856
- Pelvic Non-OB ** 76556
- Testicular / Scrotum 76870
- Soft Tissue Grain 76802

Head and Neck

- Thyroid 76536
- Neck Soft tissue 76536
- RCaretic Duplex Doppler 93980

Reason for study: _____

Breast

- Breast (Bilat) (R) (L) 76642/76641

Other: _____

* Abdominal Ultrasounds require patient not eat or drink at least 8 Hours prior to exam

** Pelvic Ultrasounds require the patient to have a full urinary bladder.

CARDIAC STUDIES:

- EKG 93000
- Holter Monitor 24 HR 93228
- Echocardiogram 93305
- Pacemaker check 93293

REQUESTING PHYSICIAN:

NAME _____ NPI # 1295026136 FAX # _____
SIGNATURE Robert Rook TODAY'S DATE _____

03/19/2025

(01052)-Ortega Karina

Date of Birth - 06/28/1983 Sex - Female Marital Status - Single

Address: 304 East 134th Street #7B, Bronx, NY, 10454
Phone #: (646) 305-0971

Social Security# - - -1234

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 02/10/2025

Time/Place Accident - East 137th Street & Willis Avenue

Policy Report - Yes

Date of Visit - 02/12/2025

Condition Related to : Auto Accident

Insurance Company : State Farm Mutual Automobile Insurance Co.

Address: P.O. Box 106170

Atlanta, GA, 30348-6170

Phone: 800-258-9884 Fax:

Claim# - 32-80N7-32S

NF-2 - Yes Sending Date - 03/05/2025

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Other Insurance -

Medicare -

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

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

Claim Number: _____

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

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained
due to the motor vehicle accident which occurred on 2/10/25, 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.

Karina Ortega
(Print name of Patient)

304 East 134th St # 7B

Bronx NY 10454
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301
(Address of Provider)

[Signature]
(Signature of Patient)

3/19/2025
(Date of signature)

[Signature]
(Signature of Provider)

3/19/2025
(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: Kawell Date: 3/19/25

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: 3/19/25

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: Kawell Date: 3/19/25

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301-0000
(201) 952-6420
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: KARINA ORTEGA
DATE OF BIRTH: 06/28/1983
ID/MRN: 20250319009
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 03/19/2025
HISTORY: M25.511-PAIN IN RIGHT SHOULDER, M25.512-PAIN IN LEFT SHOULDER

LEFT SHOULDER X-Ray Complete 2 or more views:

Normal bone density is identified. No fracture or dislocation is seen. No acute findings identified.

IMPRESSION:

No fracture, dislocation or significant abnormality noted.

RIGHT SHOULDER X-Ray Complete 2 or more views:

Normal bone density is identified. No fracture or dislocation is seen. No acute findings identified.

IMPRESSION:

No fracture, dislocation or significant abnormality noted.

Electronically Signed By: Dr. Robin Connolly M.D. 03/30/2025 20:21:09 EDT

Tech: Dynamic Mobile Xray Services LLC



DYNAMIC
MOBILE XRAY SERVICES LLC

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

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

MOBILE EXAM ORDER FORM

PATIENT INFORMATION:

NAME Karina Ortega STAT
D.O.B. _____ SS# _____ MALE FEMALE
PATIENT ADDRESS or FACILITY NAME 304 East 134th St #7B ROOM # _____
CITY Berx STATE NY ZIP 10454 PHONE 646-305-0971
PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

X-RAYS: (Mark what is needed)

CHEST AND ABDOMEN

- Abdominal KUB 1 View 74018
- Abdominal Flat & Upright 2 View 74022
- Chest 1 View 71045
- Chest AP / LAT 71046
- Ribs 2 View (R) (L) 71100
- Ribs UNILATERAL + PA Chest 3 View 71101
- Ribs BILATERAL + PA Chest 4 View 71111

HEAD AND NECK

- Skull 70250
- Facial Bones 3 View 70150
- Orbits 4 View 70200
- Nasal Bones 3 View 70150
- Mandible (R) (L) 70100
- Sinuses 70210

UPPER EXTREMITIES

- Clavicle 2 View (R) (L) 73000
- Scapula 2 View (R) (L) 73010
- Shoulder 2 View (R) (L) 73030
- Humerus 2 View (R) (L) 73060
- Elbow 3 View (R) (L) 73000
- Forearm 2 View (R) (L) 73090
- Wrist 3 View (R) (L) 73110
- Hand 3 View (R) (L) 73130
- Fingers 2 View (R) (L) 73140

SPINE AND PELVIS

- Cervical Spine AP / LAT 72040
- Thoracic Spine 3 View 72072
- Lumbar Spine 2-3 View 72100
- Pelvis 1-2 View 72170
- Sacrum Coccyx 72220

Reason for study: _____

UPPER EXTREMITIES

- HIP BILATERAL 4 View 73520
- HIP AP / LAT (R) (L) 73501
- Femur 2 View (R) (L) 73550
- Knee 1-2 View (R) (L) 73560
- Knee 3 View (R) (L) 73562
- Tibia / Fibula 2 View (R) (L) 73590
- Ankle 3 View (R) (L) 73610
- Foot 3 View (R) (L) 73630
- Heel 2 View (R) (L) 73650
- Toes 2 View (R) (L) 73660

Other: _____

Ultrasounds: (Mark what is needed)

Vascular Studies (Rule out DVT)

- Venous Upper (Bilat) (R) (L) 93970/93971
- Venous Lower (Bilat) (R) (L) 93970/93971
- Arterial Upper (Bilat) (R) (L) 93930/93931
- Arterial Lower (Bilat) (R) (L) 93925/93926
- Arterial with Ankle Brachial Index (ABI) 93922

Abdomen

- Complete Abdominal * 76770
- AORTA / AAA 76706
- Renal 76770
- Bladder ** 76857

Pelvic

- Pelvic ** 76856
- Pelvic Non-GB ** 76956
- Testicular / Scrotum 76870
- Soft Tissue Groin 76882

Head and Neck

- Thyroid 76536
- Neck Soft tissue 76536
- Carotid Duplex Doppler 93860

Reason for study: _____

Breast

- Breast (Bilat) (R) (L) 76842/76841

Other: _____

* Abdominal Ultrasounds require patient not eat or drink at least 8 Hours prior to exam

** Pelvic Ultrasounds require the patient to have a full urinary bladder.

CARDIAC STUDIES:

- EKG 93000
- Holter Monitor 24 HR 93228
- Echocardiogram 93306
- Pacemaker check 93283

REQUESTING PHYSICIAN:

NAME _____ NPI # 1295026136 FAX # _____
SIGNATURE [Signature] TODAY'S DATE 3/19/25

03/19/2025

(01053)-Ortega Manuela

Date of Birth - 04/09/1964 Sex - Female Marital Status - Married

Address: 2075 Crotona Ave #1, Bronx, NY, 10457

Phone #: (917) 609-8802

Social Security# - - -

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 02/10/2025

Time/Place Accident - East 137th Street & Willis Avenue

Policy Report - Yes

Date of Visit - 02/12/2025

Condition Related to : Auto Accident

Insurance Company : State Farm Mutual Automobile Insurance Co.

Address: P.O. Box 106170

Atlanta, GA, 30348-6170

Phone: 800-258-9884 Fax:

Claim# - 32-80N7-32S

NF-2 - Yes Sending Date - 03/05/2025

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Other Insurance -

Medicare -



DYNAMIC
MOBILE XRAY SERVICES LLC

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

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

MOBILE EXAM ORDER FORM

PATIENT INFORMATION

NAME Manuela Ortega STAT D.O.B. 4/9/1964 SS# _____ MALE FEMALE
 PATIENT ADDRESS or FACILITY NAME 2075 Crotona Ave # 1 ROOM # _____
 CITY BRONX STATE NY ZIP 10457 PHONE 917-609-8802
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

X-RAYS: (Mark what is needed)

CHEST AND ABDOMEN

- Abdominal KUB 1 View 74018
- Abdominal Flat & Upright 2 View 74022
- Chest 1 View 71045
- Chest AP / LAT 71046
- Ribs 2 View (R) (L) 71000
- Ribs UNILATERAL - PA Chest 3 View 71001
- Ribs BILATERAL - PA Chest 4 View 71111

HEAD AND NECK

- Skull 70250
- Facial Bones 5 View 70150
- Orbits 4 View 70200
- Nasal Bones 3 View 70160
- Mandible (R) (L) 70100
- Sinuses 70210

UPPER EXTREMITIES

- Clavicle 2 View (R) (L) 73000
- Scapula 2 View (R) (L) 73010
- Shoulder 2 View (R) (L) 73030
- Humerus 2 View (R) (L) 73060
- Elbow 3 View (R) (L) 73080
- Forearm 2 View (R) (L) 73090
- Wrist 3 View (R) (L) 73110
- Hand 3 View (R) (L) 73130
- Fingers 2 View (R) (L) 73140

SPINE AND PELVIS

- Cervical Spine AP / LAT 72040
- Thoracic Spine 3 View 72072
- Lumbar Spine 2-3 View 72100
- Pelvis 1-2 View 72170
- Sacrum Coccyx 72220

Reason for study: _____

UPPER EXTREMITIES

- HIP BILATERAL 4 View 73520
- HIP AP / LAT (R) (L) 73501
- Femur 2 View (R) (L) 73560
- Knee 1-2 View (R) (L) 73560
- Knee 3 View (R) (L) 73562
- Tibia / Fibula 2 View (R) (L) 73590
- Ankle 3 View (R) (L) 73510
- Foot 3 View (R) (L) 73630
- Heel 2 View (R) (L) 73650
- Toes 2 View (R) (L) 73660

Other: _____

Ultrasounds: (Mark what is needed)

Vascular Studies (Rule out DVT)

- Venous Upper (Bilat) (R) (L) 93970/93971
- Venous Lower (Bilat) (R) (L) 93970/93971
- Arterial Upper (Bilat) (R) (L) 93930/93931
- Arterial Lower (Bilat) (R) (L) 93925/93926
- Arterial with Ankle-Brachial Index (ABI) 93922

Abdomen

- Complete Abdominal * 76770
- AORTA / AAA 76706
- Renal 76770
- Bladder ** 76857

Pelvic

- Pelvic ** 76956
- Pelvic Non-OB ** 76956
- Testicular / Scrotum 76870
- Soft Tissue Grain 76802

Head and Neck

- Thyroid 76536
- Neck Soft tissue 76536
- RCaretic Duplex Doppler 93860

Reason for study: _____

Breast

- Breast (Bilat) (R) (L) 76642/76641

Other: _____

* Abdominal Ultrasounds require patient not eat or drink at least 8 Hours prior to exam

** Pelvic Ultrasounds require the patient to have a full urinary bladder.

CARDIAC STUDIES:

- EKG 93000
- Holter Monitor 24 HR 93228
- Echocardiogram 93306
- Pacemaker check 93293

REQUESTING PHYSICIAN:

NAME _____ NPI # 1295026136 FAX # _____
 SIGNATURE [Signature] TODAY'S DATE 3/19/2025

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

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

Claim Number: _____

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

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained
due to the motor vehicle accident which occurred on 2/10/25, 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.

Manuela Ortega
(Print name of Patient)
2075 Crotona Ave #1
Bx NY 10457
(Address of Patient)

Manuela Ortega
(Signature of Patient)
3/19/2025
(Date of signature)

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

[Signature]
(Signature of Provider)
3/19/2025
(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: Maurel Ostig Date: 3, 19, 2025

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: 3/19/2025

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: Maurel Ostig Date: 3/19/2025

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301-0000
(201) 952-6420
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: MANUELA ORTEGA
DATE OF BIRTH: 04/09/1964
ID/MRN: 20250319010
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 03/19/2025
HISTORY: M25.511-PAIN IN RIGHT SHOULDER, M25.512-PAIN IN LEFT SHOULDER

LEFT SHOULDER X-Ray Complete 2 or more views:

Normal bone density is identified. No fracture or dislocation is seen. No acute findings identified.

IMPRESSION:

No fracture, dislocation or significant abnormality noted.

RIGHT SHOULDER X-Ray Complete 2 or more views:

Normal bone density is identified. No fracture or dislocation is seen. No acute findings identified.

IMPRESSION:

No fracture, dislocation or significant abnormality noted.

Electronically Signed By: Dr. Robin Connolly M.D. 03/30/2025 20:20:02 EDT

Tech: Dynamic Mobile Xray Services LLC

03/19/2025

(01051)-Razo Miguel A.

Date of Birth - 07/19/1966 Sex - Male Marital Status - Single

Address: 2075 Crotona Avenue #1, Bronx, NY, 10457

Phone #: (646) 469-1418

Social Security# - - -1605

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 02/10/2025

Time/Place Accident - East 137th Street & Willis Avenue

Policy Report - Yes

Date of Visit - 02/12/2025

Condition Related to : Auto Accident

Insurance Company : State Farm Mutual Automobile Insurance Co.

Address: P.O. Box 106170

Atlanta, GA, 30348-6170

Phone: 800-258-9884 Fax:

Claim# - 32-80N7-32S

NF-2 - Yes Sending Date - 03/05/2025

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Other Insurance -

Medicare -

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

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

Claim Number: _____

I, Miguel Nazo ("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 2/16/25, not withstanding any other agreement
(Print accident date)
to the contrary.

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

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

Miguel Nazo
(Print name of Patient)

2075 Crotona Ave #1

BRONX NY 10457
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301
(Address of Provider)

[Signature]
(Signature of Patient)

3/19/2025
(Date of signature)

[Signature]
(Signature of Provider)

3/19/2025
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

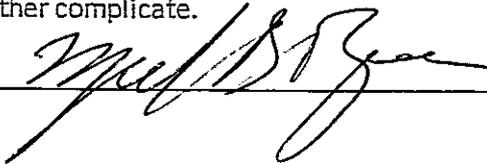
EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

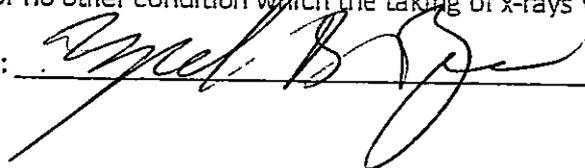
Parent Consent To X-Ray:

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: 3, 19, 25

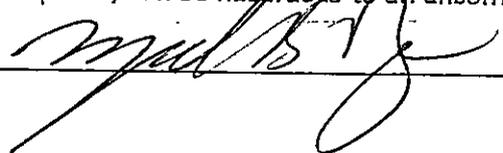
Consent To X-Ray:

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: 3/19/25

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: 3/19/25

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301-0000
(201) 952-6420
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: MIGUEL RAZO
DATE OF BIRTH: 07/19/1966
ID/MRN: 20250319011
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 03/19/2025
HISTORY: M25.511-PAIN IN RIGHT SHOULDER, M25.512-PAIN IN LEFT SHOULDER

SIGNIFICANT FINDINGS

LEFT SHOULDER X-Ray Complete 2 or more views:

Normal bone density is identified. No fracture or dislocation is seen. No acute findings identified.

IMPRESSION:

No fracture, dislocation or significant abnormality noted. Some motion artifact seen artifact in the soft tissue seen of indeterminate etiology.

RIGHT SHOULDER X-Ray Complete 2 or more views:

Normal bone density is identified. No fracture or dislocation is seen. No acute findings identified.

IMPRESSION:

No fracture, dislocation or significant abnormality noted.

Electronically Signed By: Dr. Robin Connolly M.D. 03/30/2025 20:21:46 EDT

Tech: Dynamic Mobile Xray Services LLC



DYNAMIC
MOBILE XRAY SERVICES LLC

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

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

MOBILE EXAM ORDER FORM

PATIENT INFORMATION:

NAME Miguel Razo STAT D.O.B. 2/19/1966 SS# _____ MALE FEMALE
 PATIENT ADDRESS or FACILITY NAME 2075 Crotona Ave # 1 ROOM # _____
 CITY Bronx STATE NY ZIP 10452 PHONE _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

X-RAYS: (Mark what is needed)

CHEST AND ABDOMEN

- Abdominal KUB 1 View 74018
- Abdominal Flat & Upright 2 View 74045
- Chest 1 View 71045
- Chest AP / LAT 71046
- Ribs 2 View (R) (L) 71100
- Ribs UNILATERAL + PA Chest 3 View 71101
- Ribs BILATERAL + PA Chest 4 View 71111

HEAD AND NECK

- Skull 70250
- Facial Bones 5 View 70150
- Orbits 4 View 70200
- Nasal Bones 3 View 70150
- Mandible (R) (L) 70100
- Sinuses 70210

UPPER EXTREMITIES

- Clavicle 2 View (R) (L) 73000
- Scapula 2 View (R) (L) 73010
- Shoulder 2 View (R) (L) 73030
- Humerus 2 View (R) (L) 73060
- Elbow 3 View (R) (L) 73080
- Forearm 3 View (R) (L) 73090
- Wrist 3 View (R) (L) 73110
- Hand 3 View (R) (L) 73130
- Fingers 2 View (R) (L) 73140

SPINE AND PELVIS

- Cervical Spine AP / LAT 72040
- Thoracic Spine 3 View 72072
- Lumbar Spine 2-3 View 72100
- Pelvis 1-2 View 72170
- Sacrum Coccyx 72220

UPPER EXTREMITIES

- HIP BILATERAL 4 View 73520
- HIP AP / LAT (R) (L) 73501
- Femur 2 View (R) (L) 73550
- Knee 1-2 View (R) (L) 73550
- Knee 3 View (R) (L) 73562
- Tibia / Fibula 2 View (R) (L) 73590
- Ankle 3 View (R) (L) 73610
- Foot 3 View (R) (L) 73650
- Heel 2 View (R) (L) 73650
- Toes 2 View (R) (L) 73660

Other: _____

Reason for study: _____

Ultrasounds: (Mark what is needed)

Vascular Studies (Rule out DVT)

- Venous Upper (Bilat) (R) (L) 93970/93971
- Venous Lower (Bilat) (R) (L) 93970/93971
- Arterial Upper (Bilat) (R) (L) 93930/93931
- Arterial Lower (Bilat) (R) (L) 93925/93926
- Arterial with Ankle Brachial Index (ABI) 93922

Abdomen

- Complete Abdominal * 76770
- AORTA / AAA 76706
- Renal 76770
- Bladder ** 76857

Pelvic

- Pelvic ** 76856
- Pelvic Non-GB ** 76856
- Testicular / Scrotum 76870
- Soft Tissue Groin 76880

Head and Neck

- Thyroid 76536
- Neck Soft tissue 76536
- RCerebral Duplex Doppler 93880

Reason for study: _____

Breast

- Breast (Bilat) (R) (L) 76642/76641

Other: _____

* Abdominal Ultrasounds require patient not eat or drink at least 8 Hours prior to exam

** Pelvic Ultrasounds require the patient to have a full urinary bladder.

CARDIAC STUDIES:

- EKG 93000
- Holter Monitor 24 HR 93228
- Echocardiogram 93306
- Pacemaker check 93293

REQUESTING PHYSICIAN:

NAME _____ NPI # 1295026136 FAX # _____
 SIGNATURE [Signature] TODAY'S DATE 3/19/2025

(01025)-Mattis Kerida

Date of Birth - 07/15/1984 Sex - Male Marital Status - Single

Address: 3904 Pratt Avenue 2nd FL, Bronx, NY, 10466
Phone #: (323) 425-7913

Social Security# -

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 12/16/2024

Time/Place Accident - Lafayette / Station PL

Policy Report - Yes

Date of Visit - 12/23/2024

Condition Related to : Auto Accident

Insurance Company : Progressive Advanced Insurance Company

Address:

Phone: Fax:

Claim# - 24-774986687

NF-2 - Yes Sending Date - 01/09/2025

Policy Adjuster - Kathleen Snyder 518-560-3456

F:800-776-4737

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Other Insurance -

Medicare -

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301-0000
(201) 952-6420
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: KERIDA MATTIS
DATE OF BIRTH: 07/15/1984
ID/MRN: 20250319012
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 03/19/2025
HISTORY: M25.512-PAIN IN LEFT SHOULDER

LEFT SHOULDER X-Ray Complete 2 or more views:

Normal bone density is identified. No fracture or dislocation is seen. No acute findings identified.

IMPRESSION:

No fracture, dislocation or significant abnormality noted.

Electronically Signed By: Dr. Robin Connolly M.D. 03/30/2025 20:22:33 EDT

Tech: Dynamic Mobile Xray Services LLC

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

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

Claim Number: _____

I, Kerida Mattis ("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 12/16/24, 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.

Kerida Mattis
(Print name of Patient)
3904 Pratt Ave 2nd fl
Brox NY 10466
(Address of Patient)

[Signature]
(Signature of Patient)
3/19/2025
(Date of signature)

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

[Signature]
(Signature of Provider)
3/19/2025
(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: K. Mattis Date: 3/19/25

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: 3/19/25

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: K. Mattis Date: 3/19/25



DYNAMIC
MOBILE XRAY SERVICES LLC

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

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

MOBILE EXAM ORDER FORM

PATIENT INFORMATION

NAME Kerida Mattis STAT
D.O.B: 7/15/1984 SS# _____ MALE FEMALE
PATIENT ADDRESS or FACILITY NAME 3904 Pratt Ave 2nd fl ROOM # _____
CITY BRONX STATE NY ZIP 10460 PHONE 323-425-7913
PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

X-RAYS: (Mark what is needed)

CHEST AND ABDOMEN

- Abdominal KUB 1 View 7408
- Abdominal Flat & Upright 2 View 7402
- Chest 1 View 71045
- Chest AP / LAT 71046
- Ribs 2 View (R) (L) 71100
- Ribs UNILATERAL + PA Chest 3 View 71101
- Ribs BILATERAL + PA Chest 4 View 7111

HEAD AND NECK

- Skull 70250
- Facial Bones 3 View 70150
- Orbits 4 View 70200
- Nasal Bones 3 View 70180
- Mandible (R) (L) 70100
- Sinuses 70210

UPPER EXTREMITIES

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- Tibia / Fibula 2 View (R) (L) 73590
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Reason for study: _____

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- Arterial with Ankle-Brachial Index (ABI) 93922

Abdomen

- Complete Abdominal * 76770
- AORTA + AAA 76705
- Renal 76770
- Bladder ** 76857

Pelvic

- Pelvic ** 76856
- Pelvic Non-OB ** 76556
- Testicular / Scrotum 76870
- Soft Tissue Groin 76802

Head and Neck

- Thyroid 76536
- Neck Soft tissue 76536
- R Carotid Duplex Doppler 93880

Reason for study: _____

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- Breast (Bilat) (R) (L) 76642/76641

Other: _____

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- Echocardiogram 93306
- Pacemaker check 93293

REQUESTING PHYSICIAN:

NAME _____ NPI # 1295026136 FAX # _____
SIGNATURE [Signature] TODAY'S DATE 03/19/25