

Satchan 12 patients

Patient Sign-In

Date: 4/7/25

Please sign-in and notify us if:

- New Patient
- Phone/address change
- Insurance Change

NO.	Patient Name Please Print	Appt. Time	Arrival Time	Appt. with	New Patient (✓)	Phone/address Change (✓)	Insurance Change (✓)
1	1 Hemeny Lydia			etc		etc	etc
2	2 Obite Keshen			etc		etc	etc
3	3 Metaling Agim			etc		etc	etc
4	4 Howell Jeanette			etc		etc	etc
5	5 Clark Ayan			etc		etc	etc
6	6 Espinosa Katerin			etc		etc	etc
7	7 Drake Jalice			etc		etc	etc
8	8 Douglas Fralcy			etc		etc	etc
9	9 Freyo Stefan			etc		etc	etc
10	10 Chamber Sophie			etc		etc	etc
11	11 Cumar Jernan			etc		etc	etc
12	12 Jagindrah Kumar			etc		etc	etc
13	13						
14	14						
15	15						
16	16						
17	17						
18	18						
19	19						
20	20						
21	21						
22	22						
23	23						
24	24						
25	25						

~~etc~~

04/07/2025

(01070)-Metaliag Agim

Date of Birth - 11/20/1965 Sex - Male Marital Status - Married

Address: 274 Mile Square RD, Yonkers, NY, 10701

Phone #: (917) 742-5148

Social Security# - - -4255

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 02/20/2025

Time/Place Accident - ccp W/B N Columbus / ccp W/B N Columbus

Policy Report - Yes

Date of Visit - 03/13/2025

Condition Related to : Auto Accident

Insurance Company : Farmers Insurance

Address:

Phone: Fax:

Claim# - 5035369292-1

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

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, _____, ("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)

(Signature of Patient)
4/7/25
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

(Signature of Provider)
4/7/2025
(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: *Agian Metole* Date: 4/7/25

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

4/7/25

PATIENT INFORMATION

NAME Melquay Agum STAT
D.O.B. _____ 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 70160
- Mandible (R) (L) 70130
- 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 72160
- 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) 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: _____

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

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.

Abdomen

- Complete Abdominal* 76770
- AORTA / AAA 76708
- Renal 76770
- Bladder** 76857

Head and Neck

- Thyroid 76538
- Neck Soft tissue 76538
- R Carotid Duplex Doppler 93880

Reason for study: _____

CARDIAC STUDIES

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

REQUESTING PHYSICIAN

NAME ROBERT ROOK NPI # 1295026136 FAX # _____
SIGNATURE ROBERT ROOK TODAY'S DATE 4/7/25

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

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: METALIUG AGIM
DATE OF BIRTH: 11/20/1965
ID/MRN: MA112065
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 04/07/2025
HISTORY: M25.512-PAIN IN LEFT SHOULDER, M25.562-PAIN IN LEFT KNEE

SIGNIFICANT FINDINGS

LEFT SHOULDER X-Ray Complete 2 or more views:

Technique: Left Shoulder, 2 views
Comparison: None.

Findings: There is no radiographic evidence of acute fracture or dislocation. The humeral head and neck as well as clavicle and scapula are intact. Visualized lung parenchyma is clear. The bony mineralization is mildly decreased. Moderate narrowing of gleno-humeral joint space and AC joints.

IMPRESSION:

1. No definite radiographic evidence of acute fracture or dislocation. If there are persistent symptoms, follow up x ray or CT may be obtained as clinically warranted.
2. Mild degree of osteopenia.
3. Moderate osteoarthritis.

LEFT KNEE X-Ray - 1-2 view:

Technique: Left knee, 2 views
Comparison: None.

Findings: There is evidence of total knee replacement with intact femoral and tibial components in anatomic alignment. There is no radiographic evidence of acute fracture or dislocation. There is no radiographic evidence of loosening or particle disease. The bony mineralization is mildly decreased. There is no joint effusion.

IMPRESSION:

1. Total knee replacement with intact femoral and tibial components in anatomic alignment. If there are persistent symptoms, follow up x ray may be obtained as clinically warranted.
2. No radiographic evidence of acute fracture or dislocation.
3. No radiographic evidence of loosening or particle disease.
4. Mild osteopenia demonstrated.

Electronically Signed By: Dr. Naiyer Imam M.D. 04/10/2025 2:15:17 EDT

Tech: Dynamic Mobile Xray Services LLC

04/07/2025

(01063)-Diakite Jackie

Date of Birth - 10/25/1967 Sex - Male Marital Status - Single

Address: 4020 Laconia Ave #3D, Bronx, NY, 10466
Phone #: (646) 413-9627

Social Security# - -

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 02/20/2025

Time/Place Accident - 907L S/B FDR Drive / East 71st Street

Policy Report - Yes

Date of Visit - 02/20/2025

Condition Related to : Auto Accident

Insurance Company : GEICO Indemnity Co.

Address: Geico NY PIP P.O. Box 9507

Fredericksburg, VA, 22403

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

Claim# - 8696834490000001

NF-2 - Yes Sending Date - 03/13/2025

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, Jackie Diakite, ("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 2/20/25, 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.

Jackie Diakite
(Print name of Patient)

4020 Laconia Ave #30

Bx Np. 10466
(Address of Patient)

Jackie Diakite
(Signature of Patient)

4/7/25
(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)

4/7/2025
(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: X Jackie Diakite Date: 4-7-25

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: X Jackie Diakite Date: 4-7-

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: X Jackie Diakite 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 Diakle Jaekel STAT D.O.B. _____ 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 74079
- 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 70169
- 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) 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: _____

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

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.

Abdomen

- Complete Abdominal * 76770
- AORTA / AAA 76708
- Renal 76770
- Bladder ** 76857

Head and Neck

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

Reason for study: _____

CARDIAC STUDIES

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

REQUESTING PHYSICIAN

NAME ROBERT ROOK NPI # 1295026136 FAX # _____
 SIGNATURE [Signature] TODAY'S DATE ROBERT ROOK 4/7/23

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

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: DIAKE JACKIE
DATE OF BIRTH: 10/25/1967
ID/MRN: DJ102567
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 04/07/2025
HISTORY: M25.512-PAIN IN LEFT SHOULDER, M25.562-PAIN IN LEFT KNEE

LEFT SHOULDER X-Ray Complete 2 or more views:

LEFT SHOULDER: The bones and joints of the left shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

IMPRESSION:

Negative left shoulder.

LEFT KNEE X-Ray - 1-2 view:

Evidence of previous fracture deformity distal femur noted. No acute bony abnormalities noted. Soft tissues unremarkable.

IMPRESSION:

Evidence of previous fracture deformity distal femur noted. No acute bony abnormalities noted.

Electronically Signed By: Steven Brownstein MD 04/10/2025 8:55:45 EDT

Tech: Dynamic Mobile Xray Services LLC

04/07/2025

(01072)-Douglas Tracey M.

Date of Birth - 08/16/1973 Sex - Male Marital Status - Single

Address: 342 Tecumseh Avenue, Mount Vernon, NY, 10553
Phone #: (917) 592-1580

Social Security# - - -9913

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 03/05/2025

Time/Place Accident - East Gun Hill Rd / Jerome Avenue

Policy Report - Yes

Date of Visit - 03/24/2025

Condition Related to : Auto Accident

Insurance Company : GEICO Indemnity Co.

Address: Geico NY PIP P.O. Box 9507

Fredericksburg, VA, 22403

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

Claim# - 0110352980101223

NF-2 - Yes Sending Date - 04/01/2025

Policy Effective Date -

Policy# - 0104689807

Policy holder - Fedak John M

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, Tracey Douglas ("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 3/5/25, not withstanding any other agreement
(Print accident date)

to the contrary.

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Tracey Douglas
(Print name of Patient)

[Signature]
(Signature of Patient)

342 Teamseh Ave

4/7/25
(Date of signature)

Mount Vernon NY 10553
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

4/7/2025
(Date of signature)

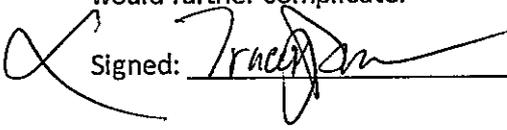
EAST STROUDSBURG PA 18301
(Address of Provider)

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: 4/7/25

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 Tracey Douglas STAT D.O.B. 8/16/73 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 70160
- Mandible (R) (L) 70190
- 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) 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) 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

Pelvic

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

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.

Abdomen

- Complete Abdominal* 76770
- AORTA / AAA 76708
- Renal 76770
- Bladder ** 76857

Head and Neck

- Thyroid 78536
- Neck Soft tissue 78536
- RCarotid Duplex Doppler 93880

Reason for study: _____

CARDIAC STUDIES

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

REQUESTING PHYSICIAN

NAME ROBERT ROOK NPI # 1295026136 FAX # _____
 SIGNATURE [Signature] TODAY'S DATE 4/7/2025

NOTE TO OFFICIALS: A portable X-RAY is being ordered since this patient would find it physically and/or psychologically taxing because of advanced age and/or

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: DOUGLAS TRACEY
DATE OF BIRTH: 08/16/1973
ID/MRN: DT081673
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 04/07/2025
HISTORY: M25.511-PAIN IN RIGHT SHOULDER, M25.561-PAIN IN RIGHT KNEE

RIGHT SHOULDER X-Ray Complete 2 or more views:

RIGHT SHOULDER: The bones and joints of the right shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

IMPRESSION:

Negative right shoulder.

RIGHT KNEE X-Ray - 1-2 view:

RIGHT KNEE: There is no evidence of bone or joint pathology. There are no signs of fracture or Dislocation.

IMPRESSION:

Negative right knee.

Electronically Signed By: Steven Brownstein MD 04/10/2025 8:55:10 EDT

Tech: Dynamic Mobile Xray Services LLC

04/07/2025

(01026)-Cummins Jermaine H.

Date of Birth - 07/22/1984 Sex - Male Marital Status - Single

Address: 86 Hamilton Avenue #4B, Yonkers, NY, 10705
Phone #: (914) 770-0330

Social Security# - - -7981

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 12/14/2024

Time/Place Accident - CCP EB-Gramatan / Gramatan Avenue (Mount Vernon)

Policy Report - Yes

Date of Visit - 12/23/2024

Condition Related to : Auto Accident

Insurance Company : GEICO Indemnity Co.

Address: Geico NY PIP P.O. Box 9507

Fredericksburg, VA, 22403

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

Claim# - 0510582350101092

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

Policy Effective Date -

Policy# -

Policy holder - Cummins, Jermaine H

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, Jermaine Cummins, ("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 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.

Jermaine Cummins
(Print name of Patient)
86 Hamilton Ave APT 4B
Yonkers NY 10705
(Address of Patient)

Jermaine Cummins
(Signature of Patient)
4/7/25
(Date of signature)

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

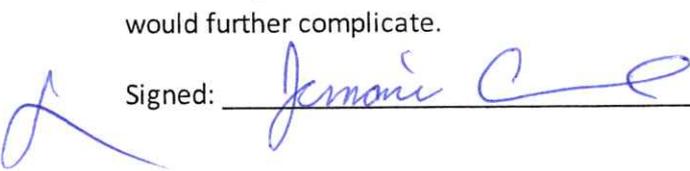
[Signature]
(Signature of Provider)
4/7/25
(Date of signature)

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: 4/7/25

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 Cummins, Jonathan STAT D.O.B. 7/27/84 SS# 123456789 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 74018
- Abdominal Flat & Upright 2 View 7402
- Chest 1 View 71045
- Chest AP / LAT 71046
- Ribs 2 View (R) (L) 71109
- 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 70169
- Mandible (R) (L) 70138
- Sinuses 70219

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) 73090
- 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 72160
- 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

Pelvic

- Pelvic ** 76856
- Pelvic Non-D9 ** 76956
- Testicular / Scrotum 76870
- Soft Tissue Groin 76862

Breast

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

Other: _____

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

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

Head and Neck

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

Reason for study: _____

Abdomen

- Complete Abdominal * 76770
- AORTA / AAA 76708
- Renal 76770
- Bladder ** 76857

CARDIAC STUDIES

- EKG 93000
- Holter Monitor 24 HR 93228
- Echocardiogram 93308
- Pacemaker check 93253

REQUESTING PHYSICIAN

NAME ROBERT ROOK NPI # 1295026136 FAX # _____
 SIGNATURE [Signature] TODAY'S DAT 4/7/25 ROBERT ROOK

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

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: CUMMINS JERMAINE
DATE OF BIRTH: 07/22/1984
ID/MRN: CJ0722284
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 04/07/2025
HISTORY: M25.512-PAIN IN LEFT SHOULDER

LEFT SHOULDER X-Ray Complete 2 or more views:

No fracture subluxation noted. No abnormal masses or calcifications noted.

IMPRESSION:

No significant abnormalities noted

Electronically Signed By: Steven Brownstein MD 04/10/2025 8:53:47 EDT

Tech: Dynamic Mobile Xray Services LLC

04/07/2025

(01071)-Chambers Sophia A.

Date of Birth - 03/04/1973 Sex - Female Marital Status - Single

Address: 408 South 4th Avenue, Mount Vernon, NY, 10550

Phone #: (917) 930-3051

Social Security# -

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 03/05/2025

Time/Place Accident -

Date of Visit - 03/06/2025

Condition Related to : Auto Accident

Insurance Company : GEICO Indemnity Co.

Address: Geico NY PIP P.O. Box 9507

Fredericksburg, VA, 22403

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

Claim# - 0671669330000001

NF-2 - Yes Sending Date - 03/25/2025

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, Sophia Chambers, ("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 3/5/25, 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.

Sophia Chambers
(Print name of Patient)

408 South 4th Ave

Mount Vernon NY 10550
(Address of Patient)

X [Signature]
(Signature of Patient)

4/7/25
(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)

4/7/2025
(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: _____

Shaw

Date: _____

4/7/25

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

4/7/25

PATIENT INFORMATION

NAME Sophia Chambers STAT D.O.B. _____ 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 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) 70130
- Sinuses 70230

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

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) 73650

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) 93950/93951
- Arterial Lower (Bilat) (R) (L) 93925/93926
- Arterial with Ankle-Brachial Index (ABI) 93922

Pelvic

- Pelvic** 76856
- Pelvic Non-OB** 78856
- Testicular / Scrotum 76870
- Soft Tissue Groin 76882

Breast

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

* 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 76706
- Renal 76770
- Bladder** 76857

Head and Neck

- Thyroid 76538
- Neck Soft tissue 76538
- R Carotid Duplex Doppler 93880

Reason for study: _____

CARDIAC STUDIES

- EKG 83000
- Holter Monitor 24 HR 93228
- Echocardiogram 83308
- Pacemaker check 83293

REQUESTING PHYSICIAN

NAME ROBERT ROOK NPI # 1295026136 FAX # _____
 SIGNATURE [Signature] TODAY'S DATE ROBERT ROOK 04/07/25

NOTE TO OFFICIALS: A portable X-RAY is being ordered since this patient would find it physically and/or psychologically taxing, because of advanced age and/or other medical conditions. This X-RAY is being ordered for the diagnosis and treatment of this patient.

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: CHAMBER SOPHIA
DATE OF BIRTH: 03/04/1973
ID/MRN: CP030473
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 04/07/2025
HISTORY: M25.561-PAIN IN RIGHT KNEE

RIGHT KNEE X-Ray - 1-2 view:

No fracture subluxation noted. No abnormal masses or calcifications noted.

IMPRESSION:

No significant abnormalities noted

Electronically Signed By: Steven Brownstein MD 04/10/2025 8:54:23 EDT

Tech: Dynamic Mobile Xray Services LLC

04/07/2025

(01057)-Freijo Stefania

Date of Birth - 07/24/1984 Sex - Female Marital Status - Married

Address: 1061 East 211th Street, Bronx, NY, 10469

Phone #: (845) 313-1924

Social Security# - - -7747

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 02/03/2025

Time/Place Accident - East Gun Hill Rd / Bronxwood Avenue

Policy Report - Yes

Date of Visit - 02/19/2025

Condition Related to : Auto Accident

Insurance Company : GEICO Indemnity Co.

Address: Geico NY PIP P.O. Box 9507

Fredericksburg , VA, 22403

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

Claim# - 0413886950101069

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

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: _____

Stefania Freijo ("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 2/3/25, not withstanding any other agreement
(Print accident date)

to the contrary.

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

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

Stefania Freijo
(Print name of Patient)

1061 East 211th St

Bt Ny. 10469
(Address of Patient)

X Stefania Freijo
(Signature of Patient)

4/7/25
(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)

4/7/2025
(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: Stephania Lopez Date: 4/7/25

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: Stephania Lopez Date: 4/7/25



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 Joe Jo Stefana STAT D.O.B. _____ 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 70160
- Mandible (R) (L) 70139
- Sinuses 70219

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) 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

Pelvic

- Pelvic** 76856
- Pelvic Non-OB** 76856
- Testicular / Scrotum 76870
- Soft Tissue Groin 76862

Breast

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

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 76706
- Renal 76770
- Bladder** 76857

Head and Neck

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

Reason for study: _____

CARDIAC STUDIES

- EKG 83000
- Holter Monitor 24 HR 93228
- Echocardiogram 93308
- Pacemaker check 83293

REQUESTING PHYSICIAN

NAME ROBERT ROOK NPI # 1295026136 FAX # _____
 SIGNATURE ROBERT ROOK TODAY'S DAT 04/07/2028

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

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: FREIJO STEFANIA
DATE OF BIRTH: 07/27/1984
ID/MRN: FS072484
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 04/07/2025
HISTORY: M25.512-PAIN IN LEFT SHOULDER

LEFT SHOULDER X-Ray Complete 2 or more views:

LEFT SHOULDER: The bones and joints of the left shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

IMPRESSION:

Negative left shoulder.

Electronically Signed By: Steven Brownstein MD 04/10/2025 8:54:34 EDT

Tech: Dynamic Mobile Xray Services LLC

04/07/2025

(01048)-Espinosa Katerin

Date of Birth - 07/04/1992 Sex - Female Marital Status - Single

Address: 1535 Undercliff Avenue #17, Bronx, NY, 10453

Phone #: (917) 345-6504

Social Security# - - -1323

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 02/02/2025

Time/Place Accident - Sedgwick and Diplo Place / Major Degan Exit

Policy Report - Yes

Date of Visit - 02/04/2025

Condition Related to : Auto Accident

Insurance Company : GEICO Indemnity Co.

Address: Geico NY PIP P.O. Box 9507

Fredericksburg , VA, 22403

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

Claim# - 8806760830000001

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

Policy Effective Date -

Policy# - 6155830935

Policy holder - Esinosa Gabino K

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, Katerin Espinosa ("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 2/2/25, 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.

Katerin Espinosa
(Print name of Patient)
1535 Undercliff Ave #17
Bx NY 10153
(Address of Patient)

Katerin Espinosa
(Signature of Patient)
4/7/25
(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)
4/7/2025
(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: _____

Katerin Espinosa

Date: _____

4/7/25

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: _____

Katerin Espinosa

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

4/7/25

PATIENT INFORMATION

NAME Espinoza, Katerina STAT D.O.B. _____ 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 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) 70130
- 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) 73560
- Knee 3 View (R) (L) 73582
- Tibia / Fibula 2 View ... (R) (L) 73580
- 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

Pelvic

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

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.

Abdomen

- Complete Abdominal* 76770
- AORTA / AAA 76708
- Renal 76770
- Bladder** 76857

Head and Neck

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

Reason for study: _____

CARDIAC STUDIES

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

REQUESTING PHYSICIAN

NAME ROBERT ROOK NPI # 1295026136 FAX # _____
 SIGNATURE [Signature] TODAY'S DATE 4/7/25

NOTE TO OFFICIALS: A portable X-RAY is being ordered since this patient would find it physically and/or psychologically taxing because of advanced age and/or medical condition. This is medically necessary for the diagnosis and treatment of this patient.

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: ESPINOSA KATERIN
DATE OF BIRTH: 09/09/1978
ID/MRN: W454556565
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 04/07/2025
HISTORY: M25.512-PAIN IN LEFT SHOULDER, M54.6-PAIN IN THORACIC SPINE.

SPINE THORACIC X-RAY 2 view:

The thoracic vertebra appear of normal height. No fracture noted. No paraspinal soft tissue mass noted. Neural foramina appear patent.

IMPRESSION:

No significant abnormalities noted

LEFT SHOULDER X-Ray Complete 2 or more views:

LEFT SHOULDER: The bones and joints of the left shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

IMPRESSION:

Negative left shoulder.

Electronically Signed By: Steven Brownstein MD 04/10/2025 8:56:29 EDT

Tech: Dynamic Mobile Xray Services LLC

(01064)-Clark Ayana

Date of Birth - 06/30/1978 Sex - Female Marital Status - Single

Address: 1575 Odell St #9H, Bronx, NY, 10462
Phone #: (917) 667-1716

Social Security# -

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 03/02/2025

Time/Place Accident - 95i W/B Cross Bronx Expy / 100 Feet E/O Arthur Ave Overpass

Policy Report - Yes

Date of Visit - 03/05/2025

Condition Related to : Auto Accident

Insurance Company : GEICO Indemnity Co.

Address: Geico NY PIP P.O. Box 9507

Fredericksburg, VA, 22403

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

Claim# - 8790156860000003

NF-2 - Yes Sending Date - 03/25/2025

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, Ayana Clark, ("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 3/2/25, 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.

Ayana Clark
(Print name of Patient)

1575 adell st #9H

Brox NY 10462
(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)

4/7/25
(Date of signature)

[Signature]
(Signature of Provider)

4/7/2025
(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: _____

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

4/7/25

PATIENT INFORMATION

NAME Ayana Clark STAT D.O.B. _____ 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 1View 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) 70133
- Sinuses 70219

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 72160
- 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) 73580
- 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) 93570/93971
- Arterial Upper (Bilat) (R) (L) 93950/93931
- Arterial Lower (Bilat) (R) (L) 93925/93926
- Arterial with Ankle-Brachial Index (ABI) 93922

Pelvic

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

Breast

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

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 ** 76857

Head and Neck

- Thyroid 76536
- Neck Soft tissue 76538
- R Carotid Duplex Doppler 93880

Reason for study: _____

CARDIAC STUDIES

- EKG 83000
- Holter Monitor 24 HR 93228
- Echocardiogram 93308
- Pacemaker check 93293

REQUESTING PHYSICIAN

NAME ROBERT ROOK NPI # 1295026136 FAX # _____
SIGNATURE ROBERT ROOK TODAY'S DATE 4/7/25

NOTE TO OFFICIALS: A portable X-RAY is being ordered since this patient would find it physically and/or psychologically taxing because of advanced age and/or

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: CLARK AYANA
DATE OF BIRTH: 06/30/1978
ID/MRN: CA063060
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 04/07/2025
HISTORY: M25.511-PAIN IN RIGHT SHOULDER

RIGHT SHOULDER X-Ray Complete 2 or more views:

RIGHT SHOULDER: The bones and joints of the right shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

IMPRESSION:

Negative right shoulder.

Electronically Signed By: Steven Brownstein MD 04/10/2025 8:56:37 EDT

Tech: Dynamic Mobile Xray Services LLC

04/07/2025

(01050)-Howell Jeannette

Date of Birth - 05/12/1961 Sex - Female Marital Status - Single

Address: 85 Highland Avenue #5G, Yonkers, NY, 10705

Phone #: (917) 686-5471

Social Security# - - -3052

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 02/05/2025

Time/Place Accident -

Date of Visit - 02/10/2025

Condition Related to : Auto Accident

Insurance Company : State Farm Fire & Casualty Co.

Address:

Phone: 800-258-9884 Fax:

Claim# - 5280K186V

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

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: _____

Jeannette Howell ("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 2/5/23, 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.

Jeannette Howell
(Print name of Patient)

85 Highland Ave #5G

Yonkers NY 10705
(Address of Patient)

Jeannette Howell
(Signature of Patient)

4/7/23
(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)

4/7/2023
(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: Jeannette Howell Date: 4/7/2025

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: _____

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: Jeannette Howell Date: 4/7/2025



DYNAMIC
MOBILE XRAY SERVICES LLC

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

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

MOBILE EXAM ORDER FORM

4/7/25

PATIENT INFORMATION

NAME Jeanette Howell STAT D.O.B. _____ 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 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) 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) 73560
- Knee 3 View (R) (L) 73562
- Tibia / Fibula 2 View (R) (L) 73590
- Ankle 2 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) 93570/93971
- Arterial Upper (Bilat) (R) (L) 93930/93931
- Arterial Lower (Bilat) (R) (L) 93925/93926
- Arterial with Ankle-Brachial Index (ABI) 93922

Pelvic

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

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.

Abdomen

- Complete Abdominal * 76770
- AORTA / AAA 76708
- Renal 76770
- Bladder ** 76857

Head and Neck

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

Reason for study: _____

CARDIAC STUDIES

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

REQUESTING PHYSICIAN

NAME ROBERT ROOK NPI # 1295026136 FAX # _____
 SIGNATURE Robert Rook TODAY'S DATE 4/7/25

NOTE TO OFFICIALS: A portable X-RAY is being ordered since this patient would find it physically and/or psychologically taxing because of advanced age and/or other medical conditions. This test is medically necessary for the diagnosis and treatment of this patient.

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: HOWELL JEANETTE
DATE OF BIRTH: 05/12/1961
ID/MRN: HJ051261
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 04/07/2025
HISTORY: M79.621-PAIN IN RIGHT UPPER ARM, M25.571-PAIN IN RIGHT ANKLE AND JOINTS OF RIGHT FOOT

RIGHT HUMERUS X-Ray - 2 view:

Mild degenerative changes noted. Bony infarct humeral head noted. No fracture identified.

IMPRESSION:

Mild degenerative changes noted. Bone infarct humeral head noted. No fracture subluxation noted.

RIGHT ANKLE X-Ray - 2 views:

No fracture subluxation noted. Ankle mortise well maintained. Plantar heel spur noted.

IMPRESSION:

Plantar heel spur noted. Remainder study unremarkable.

Electronically Signed By: Steven Brownstein MD 04/10/2025 9:46:14 EDT

Tech: Dynamic Mobile Xray Services LLC

04/07/2025

(01065)-Obite Kesiena N.

Date of Birth - 03/27/1982 Sex - Male Marital Status - Married

Address: 2758 Sexton Place #2, Bronx, NY, 10469

Phone #: (347) 607-0714

Social Security# - - -9212

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 02/26/2025

Time/Place Accident - E. Gun Hill Rd / Sexton PL

Policy Report - Yes

Date of Visit - 03/05/2025

Condition Related to : Auto Accident

Insurance Company : HereFord Insurance

Address:

Phone: Fax:

Claim# - 20903649

NF-2 - Yes Sending Date - 03/13/2025

Policy Effective Date -

Policy# - 8555271

Policy holder - Kesiena N. Obite

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, Kesiena Obite, ("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
(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.

Kesiena Obite
(Print name of Patient)

2758 Seaton PL #2

BX NY, 10469
(Address of Patient)

X [Signature]
(Signature of Patient)

4/7/25
(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)

4/7/2025
(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: _____

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

4/7/28

PATIENT INFORMATION

NAME Mesera Obate STAT D.O.B. _____ 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 74018
- Abdominal Flat & Upright 2 View 7402
- Chest 1 View 71045
- Chest AP / LAT 71046
- Ribs 2 View (R) (L) 71109
- Ribs UNILATERAL + PA Chest 3 View 71101
- Ribs BILATERAL + PA Chest 4 View 71111

HEAD AND NECK

- Skull 70250
- Facial Bones 3 View 70159
- 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 2 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) 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

Pelvic

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

Breast

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

Other: _____

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

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

Abdomen

- Complete Abdominal * 76770
- AORTA / AAA 76708
- Renal 76770
- Bladder ** 76857

Head and Neck

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

Reason for study: _____

CARDIAC STUDIES

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

REQUESTING PHYSICIAN

NAME ROBERT ROOK NPI # 1295026136 FAX # _____

SIGNATURE [Signature] TODAY'S DAT 4/7/25

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

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: OBITE KESIENA
DATE OF BIRTH: 03/27/1982
ID/MRN: OB03271982
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 04/07/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE.

SPINE THORACIC X-RAY 2 view:

Technique: Thoracic spine, 2 views.
Comparison: None.

Findings: There is normal alignment of thoracic spine with no subluxation. There are no compression deformities. The bony mineralization is normal.

IMPRESSION:

1. Normal alignment of thoracic spine with no subluxation.
 2. No compression deformities or fractures demonstrated radiographically. If there is persistent pain, follow up CT or MRI may be obtained as clinically warranted.
-

Electronically Signed By: Dr. Naiyer Imam M.D. 04/10/2025 5:48:48 EDT

Tech: Dynamic Mobile Xray Services LLC

04/07/2025

(01074)-Herrera Lydia S.

Date of Birth - 10/25/1989 Sex - Female Marital Status - Single

Address: 1689 Randall Ave #5D, Bronx, NY, 10473
Phone #: (347) 361-7907

Social Security# - - -8116

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 03/19/2025

Time/Place Accident - Sprain Brook Pkwy North / Greenburgh, NY

Policy Report - Yes

Date of Visit - 03/25/2025

Condition Related to : Auto Accident

Insurance Company : GEICO Indemnity Co.

Address: Geico NY PIP P.O. Box 9507

Fredericksburg, VA, 22403

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

Claim# - 8822658280000002

Policy Adjuster - Gregory Czaplak 516.714.7264

Policy Effective Date -

Policy# - 6172-84-01-64

Policy holder - Herrera Lydia

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, Lydia Herrera ("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 3/19/25, 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.

Lydia Herrera
(Print name of Patient)

1689 Randall Ave #50

Bx NY, 10473
(Address of Patient)

X Lydia Herrera
(Signature of Patient)

4/7/25
(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)

4/7/2025
(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: Lydia Herrera Date: 4/7/25

Consent To X-Ray:

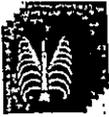
A Minor I am a parent or legal guardian of _____, who is a minor, _____ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this point I know of no other condition which the taking of x-rays would 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

4/7/25

PATIENT INFORMATION:

NAME Lydia Hewery STAT D.O.B. _____ 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 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 73189
- Mandible (R) (L) 78109
- Sinuses 78219

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 2 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) 73650
- Knee 1-2 View (R) (L) 73660
- Knee 3 View (R) (L) 73682
- Tibia / Fibula 2 View ... (R) (L) 73690
- 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

Pelvic

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

Breast

- Breast (Bilat) (R) (L) 78642/78641

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 ** 76857

Head and Neck

- Thyroid 78538
- Neck Soft tissue 78538
- RCarotid Duplex Doppler 83880

Reason for study: _____

CARDIAC STUDIES

- EKG 93000
- Holter Monitor 24 HR 93228
- Echocardiogram 93308
- Pacemaker check 83283

REQUESTING PHYSICIAN

NAME ROBERT ROOK NPI # 1295026136 FAX # _____
 SIGNATURE ROBERT ROOK TODAY'S DATE 4/7/25

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: HERERA LYDIA
DATE OF BIRTH: 10/25/1989
ID/MRN: HL1025199
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 04/07/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE.

SPINE THORACIC X-RAY 2 view:

Technique: Thoracic spine, 2 views
Comparison: None.

Findings: There is mild dextroscoliosis with no subluxation. (9 degrees Cobb's angle at T8 level). There are no compression deformities. The bony mineralization is normal.

IMPRESSION:

1. Mild dextroscoliosis with no subluxation. (9 degrees Cobb's angle at T8 level)
 2. No compression deformities or fractures demonstrated radiographically. If there is persistent pain, follow up CT or MRI may be obtained as clinically warranted.
-

Electronically Signed By: Dr. Naiyer Imam M.D. 04/10/2025 5:43:47 EDT ,

Tech: Dynamic Mobile Xray Services LLC

04/07/2025

(01046)-Jagindhrall Kumar

Date of Birth - 02/20/1982 Sex - Male Marital Status - Married

Address: 1826 Yates Avenue, Bronx, NY, 10461

Phone #: (347) 835-9967

Social Security# - - -8647

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 01/17/2025

Time/Place Accident - 159 West 48th Street (Manhattan)

Policy Report - Yes

Date of Visit - 02/04/2025

Condition Related to : Auto Accident

Insurance Company : American Transit Insurance Co.

Address:

Phone: 212-857-8200 Fax:

Claim# - 1163314

• NF-2 - Yes Sending Date - 02/04/2025

Policy Effective Date -

Policy# - B501542

Policy holder - Rattan Mohan

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

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained
due to the motor vehicle accident which occurred on 1/17/05, not withstanding any other agreement
(Print accident date)
to the contrary.

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

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

Kumar Jagindhrall
(Print name of Patient)

1826 Yates Ave

Bx Mt. Airy
(Address of Patient)

X Kumar Jagindhrall
(Signature of Patient)

4/7/25
(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)

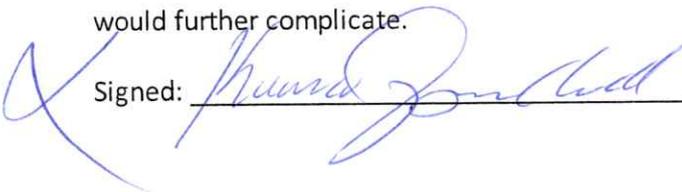
4/7/2025
(Date of signature)

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: 4/7/25

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 Jagindral Kumar STAT D.O.B. _____ 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 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) 70130
- 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) 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) 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

Pelvic

- Pelvic ** 76658
- Pelvic Non-OB ** 76656
- Testicular / Scrotum 76670
- Soft Tissue Groin 76682

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.

Abdomen

- Complete Abdominal * 76770
- AORTA / AAA 76708
- Renal 76770
- Bladder ** 76857

Head and Neck

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

Reason for study: _____

CARDIAC STUDIES

- EKG 93000
- Holter Monitor 24 HR 93228
- Echocardiogram 93308
- Pacemaker check 93283

REQUESTING PHYSICIAN

NAME ROBERT ROOK NPI # 1295026136 PAX # _____
 SIGNATURE [Signature] TODAY'S DATE 4/9/25

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

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: JAGINDHRALL KUMAR
DATE OF BIRTH: 02/20/1982
ID/MRN: JK02201982
CLINICIAN: DR. ROOK, ROBERT
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 04/07/2025
HISTORY: M25.512-PAIN IN LEFT SHOULDER

LEFT SHOULDER X-Ray Complete 2 or more views:

LEFT SHOULDER: The bones and joints of the left shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

IMPRESSION:

Negative left shoulder.

Electronically Signed By: Steven Brownstein MD 04/10/2025 9:47:00 EDT

Tech: Dynamic Mobile Xray Services LLC