

5/13/2025

LIST OF SELECTED PATIENTS

<u>Name :</u> DAVIS, JULISSA	<u>Phone:</u> 646-391-8876
<u>Address :</u> 2140 MADISON AVENUE, #9B, NEW YORK, NY 10037	<u>Active</u>
<u>D.O.A. :</u> 3/5/2025 <u>Place Of Accident :</u> N/A	
<u>SSN:</u> 052-80-2231 <u>DOB:</u> 10/31/1995 <u>Marital Status:</u> U <u>Policy Holder:</u> NO	
<u>Policy Holder</u> N/A, N/A	<u>Address:</u> N/A
<u>Ins. Company:</u> Affirmative Direct Insurance Company	<u>Phone :</u> (929)369-0649
<u>Ins. Address:</u> One MetroTech Center, Suite 1803, Brooklyn, NY, 11201	
<u>Policy Number:</u> N/A	<u>Claim Number :</u> AD25031901
<u>Adjuster Info:</u> N/A	

1100 pelham ptw  
5/13/25

nu

**DYNAMIC MOBILE XRAY SERVICES LLC**

3412 BLUESTONE LANE  
E STROUDSBURG, PA 18301-0000  
(201) 952-6420

dynamicmobilexrays@gmail.com

**Radiology Interpretation**

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**PATIENT NAME:** DAVIS JULISSA

**DATE OF BIRTH:** 10/31/1991

**ID/MRN:** 20250513122700696

**CLINICIAN:** AMANZE, STELLA . PA

**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC

**DATE OF EXAM:** 05/13/2025

**HISTORY:** M25.472-EFFUSION, LEFT ANKLE

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**LEFT ANKLE X-Ray Complete 3 view:**

No fracture subluxation noted. Ankle mortise well maintained. Base of the 5th metatarsal bone appear intact.

**IMPRESSION:**

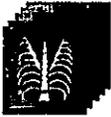
**No significant abnormalities noted**

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**Electronically Signed By:** Steven Brownstein MD 05/15/2025 21:55:35 EDT

**Tech:** Dynamic Mobile Xray Services LLC

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**ID: EC29048981-20250515210952-68269e70d2ad9**



**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 DAVIS JESSICA 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**

**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 ..... 70180
- 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) ..... 73080
- 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) ..... 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) ..... 73680

Other : \_\_\_\_\_

**Ultrasounds: (Make what is needed)**

**Vascular Studies ( Rule out DVT )**

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

**Abdomen**

- Complete Abdominal \* ..... 78770
- AORTA / AAA ..... 78708
- Renal ..... 78770
- Bladder \*\* ..... 78657

**Pelvic**

- Pelvic \*\* ..... 78858
- Pelvic Non-OB \*\* ..... 78856
- Testicular / Scrotum ..... 78870
- Soft Tissue Groin ..... 78882

**Head and Neck**

- Thyroid ..... 78538
- Neck Soft tissue ..... 78538
- RCarotid Duplex Doppler ..... 93880

Reason for study: \_\_\_\_\_

**Breast**

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

Other \_\_\_\_\_

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

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

**CARDIAC STUDIES**

- EKG ..... 83000
- Holter Monitor 24 HR ..... 93228
- Echocardiogram ..... 93389
- Pacemaker check ..... 93283

REQUESTING PHYSICIAN  
 NAME Stella Hagan NPI # 1891953238 FAX # \_\_\_\_\_  
 SIGNATURE [Signature] TODAY'S DATE 05/13/2025

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

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

Claim Number: \_\_\_\_\_

I, \_\_\_\_\_, ("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.

Missa Davis

(Print name of Patient)

Missa Davis

(Signature of Patient)

05/13/25

(Date of signature)

\_\_\_\_\_  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES

(Print name of Provider)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301

(Address of Provider)

[Signature]

(Signature of Provider)

05/13/25

(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: Juliana Davis Date: 5/13/25

**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: \_\_\_\_\_

5/13/2025

LIST OF SELECTED PATIENTS

<u>Name:</u> LEE, GUSTAVE	<u>Phone:</u> 347-691-4556
<u>Address:</u> 1031 E. 217ST, BRONX, NY 10469	<u>Active</u>
<u>D.O.A.:</u> 2/22/202 <u>Place Of Accident:</u> 278I S/B BRUCKNER EXPRESSWAY	
<u>SSN:</u> 053-78-6458 <u>DOB:</u> 11/25/196 <u>Marital Status:</u> U <u>Policy Holder:</u> YES	
<u>Policy Holder</u> LEE, GUSTAVE	<u>Address:</u> 1031 E. 217ST, BRONX, NY 10469
<u>Ins. Company:</u> GEICO	<u>Phone:</u> 888-841-3000
<u>Ins. Address:</u> P.O. BOX 9507, FREDERICKSBURG, VA 22403	
<u>Policy Number:</u> 6188103748	<u>Claim Number:</u> 8837092890000001
<u>Adjuster Info:</u> N/A	



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website: dynamicmobilexray.com

**MOBILE EXAM ORDER FORM**

**PATIENT INFORMATION**

NAME LEE Gustavo 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**

**CHEST AND ABDOMEN**

- Abdominal KUB 1 View ..... 74018
- Abdominal Flat & Upright 2 View ..... 7402
- Chest 1 View ..... 71046
- 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 ..... 70180
- 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) ..... 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) ..... 73650
- Knee 1-2 View .....  (R) .....  (L) ..... 73580
- Knee 3 View .....  (R) .....  (L) ..... 73582
- Tibia / Fibula 2 View ...  (R) .....  (L) ..... 73580
- Ankle 3 View .....  (R) .....  (L) ..... 73610
- Foot 3 View .....  (R) .....  (L) ..... 73830
- Heel 2 View .....  (R) .....  (L) ..... 73650
- Toes 2 View .....  (R) .....  (L) ..... 73880

Other: \_\_\_\_\_

**Ultrasounds**

**Vascular Studies ( Rule out DVT )**

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

**Abdomen**

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

**Pelvic**

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

**Head and Neck**

- Thyroid ..... 76536
- Neck Soft tissue ..... 76536
- RC Arterid Duplex Doppler ..... 93880

Reason for study: \_\_\_\_\_

**Breast**

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

Other: \_\_\_\_\_

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

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

**CARDIAC STUDIES**

- EKG ..... 93000
- Holter Monitor 24 HR ..... 93226
- Echocardiogram ..... 93300
- Pacemaker check ..... 93205

NAME Stella Hyman NPI # 1891953238 FAX \_\_\_\_\_  
SIGNATURE [Signature] TODAY'S DAT 05/13/2025

**DYNAMIC MOBILE XRAY SERVICES LLC**

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

---

**PATIENT NAME:** LEE GUSTAVE  
**DATE OF BIRTH:** 11/25/1966  
**ID/MRN:** 20250513130026012  
**CLINICIAN:** AMANZE, STELLA . PA  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 05/13/2025  
**HISTORY:** R07.9-CHEST PAIN, UNSPECIFIED

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**Chest X-Ray AP/LAT:**

**CXR 2 VIEW:**

The lungs are clear. The cardiomediastinal silhouette is enlarged. No pneumonia or congestive heart failure. No acute osseous abnormality.

**IMPRESSION:**

**No acute cardiopulmonary disease process.**

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**Electronically Signed By:** Dr. Yasser Mir M.D. 05/15/2025 21:53:54 EDT



**Tech:** Dynamic Mobile Xray Services LLC

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**ID: EC29048987-20250515210900-68269e3c071e0**

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

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

Claim Number: \_\_\_\_\_

I, GUSTAV LEE ("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.

GUSTAVE LEE  
(Print name of Patient)

Gustave Lee  
(Signature of Patient)

\_\_\_\_\_  
(Address of Patient)

5-13-25  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

5/13/25  
(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: GUSTAVE LEE Date: 7-13-25

**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: \_\_\_\_\_

5/13/2025

LIST OF SELECTED PATIENTS

<u>Name :</u> RUIZ LEONARDO, JOSEFINA	<u>Phone:</u> 914-349-0736
<u>Address :</u> 16 POPLAR STREET YONKERS, NY 10701	<u>Active</u>
<u>D.O.A. :</u> 4/18/202 <u>Place Of Accident :</u> N/A	
<u>SSN:</u> - - - <u>DOB:</u> 10/7/198 <u>Marital Status:</u> U <u>Policy Holder:</u> NO	
<u>Policy Holder</u> N/A, N/A	<u>Address:</u> N/A
<u>Ins. Company:</u> GEICO	<u>Phone :</u> 888-841-3000
<u>Ins. Address:</u> P.O. BOX 9507, FREDERICKSBURG, VA 22403	
<u>Policy Number:</u> N/A	<u>Claim Number :</u> N/A
<u>Adjuster Info:</u> N/A	

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**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 KUIZ JOSEFINA 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 ..... 71048
- 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 ..... 70180
- 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) ..... 73080
- Elbow 3 View .....  (R) .....  (L) ..... 73080
- Forearm 2 View .....  (R) .....  (L) ..... 73080
- 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) ..... 73650
- Knee 1-2 View .....  (R) .....  (L) ..... 73660
- Knee 3 View .....  (R) .....  (L) ..... 73682
- Tibia / Fibula 2 View ...  (R) .....  (L) ..... 73580
- Ankle 3 View .....  (R) .....  (L) ..... 73610
- Foot 3 View .....  (R) .....  (L) ..... 73830
- Heel 2 View .....  (R) .....  (L) ..... 73650
- Toes 2 View .....  (R) .....  (L) ..... 73880

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)..... 93925/93928
- Arterial with Ankle-Brachial Index (ABI) .... 93922

**Abdomen**

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

**Pelvic**

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

**Head and Neck**

- Thyroid..... 76538
- Neck Soft tissue..... 76538
- RCarotid Duplex Doppler ..... 93880

Reason for study: \_\_\_\_\_

**Breast**

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

Other \_\_\_\_\_

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

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

**CARDIAC STUDIES**

- EKG ..... 93900
- Holter Monitor 24 HR ..... 93226
- Echocardiogram ..... 93226
- Pacemaker check ..... 93293

DEBUSTING STAIN  
NAME Stella Hoyer NPI # 1891953238 FAX # \_\_\_\_\_  
SIGNATURE [Signature] TODAY'S DAT 05/13/2025

**DYNAMIC MOBILE XRAY SERVICES LLC**

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

---

**PATIENT NAME:** RUIZ JOSEFINA  
**DATE OF BIRTH:** 10/07/1982  
**ID/MRN:** 20250513152024463  
**CLINICIAN:** AMANZE, STELLA . PA  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 05/13/2025  
**HISTORY:** M25.562-PAIN IN LEFT KNEE, M79.672-PAIN IN LEFT FOOT

---

**LEFT KNEE X-Ray - 1-2 view:**

LEFT KNEE: There is no evidence of bone or joint pathology. There are no signs of fracture or dislocation

**IMPRESSION:**

Negative left knee.

---

**LEFT FOOT X-Ray Complete 3 view:**

LEFT FOOT: There are no signs of fracture or dislocation. There are no signs of joint abnormality or specific bony abnormality.

**IMPRESSION:**

Negative left foot.

---

**Electronically Signed By:** Steven Brownstein MD 05/15/2025 21:55:13 EDT

**Tech:** Dynamic Mobile Xray Services LLC

**This transmission is proprietary, privileged and confidential. It is intended to be communication only for the use of the addressee; access to this message by anyone else is unauthorized. If you are not the intended recipient and have received this communication in error, please notify us immediately at (201) 952-6420. Any other action taken, including but not limited to the disclosure, copying or distribution of this communication is prohibited by law.**  
**ID: EC29048990-20250515210756-68269dfc2d203**

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.

Josefina Ruiz  
(Print name of Patient)

[Signature]  
(Signature of Patient)

\_\_\_\_\_

05/13/25  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

05/13/25  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

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

**X-Ray Consent Form**

**Parent Consent To X-Ray:**

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

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**Consent To X-Ray:**

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

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**Females: Regarding Possibility of Pregnancy**

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

Signed: \_\_\_\_\_

Date: \_\_\_\_\_