

5/29/2025

**(01085)-Black Aisha**

Date of Birth - 4/10/1983 Sex - Female Marital Status - Single

Address: 230 West 131st Street #10B, Bronx, NY, 10027  
Phone #: (929) 465-4936

Social Security# -- -7310

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 4/16/2025  
Time/Place Accident - 5 East 47th Street  
Policy Report - Yes

Date of Visit - 4/24/2025  
Condition Related to : Auto Accident

Insurance Company : American Transit Insurance Co.  
Address:

Phone: 212-857-8200 Fax:

Claim# - 1167030  
NF-2 - Yes Sending Date - 04/24/2025  
Policy Adjuster - Mark Attias  
Policy Effective Date -  
Policy# - C201109  
Policy holder - Ahmed, Mir  
WCB# -  
Carrier case # -

Attorney - Salerno & Goldberg, PC Firm Name - Salerno & Goldberg, PC  
Attorney Address - 1955 Deer Park Avenue, NY. 11729  
Attorney Phone - 631-482-8888 Fax - 631-482-8889  
Contact Person -

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: \_\_\_\_\_

Aisha Black ("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 4/14/25, 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 DEFAUD 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.

Aisha Black  
(Print name of Patient)  
\_\_\_\_\_  
(Address of Patient)

[Signature]  
(Signature of Patient)  
5/29/2025  
(Date of signature)

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

[Signature]  
(Signature of Provider)  
05/29/2025  
(Date of signature)

**DYNAMIC MOBILE XRAY SERVICES LLC**

**3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301**

**Tel: (570) 243-1888**

**X-Ray Consent Form**

**Parent Consent To X-Ray:**

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

✓ Signed: [Signature] Date: 05/29/2025

**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: [Signature] Date: 05/29/2025

**Females: Regarding Possibility of Pregnancy**

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

✓ Signed: [Signature] Date: 05/29/25

05/29/2025

**(01090)-Herbert Chinasha**

Date of Birth - 01/14/1994 Sex - Female Marital Status - Single

Address: 950 Mace Ave #2B, Bronx, NY, 10469  
Phone #: (618) 802-2268

Social Security# -

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 05/16/2025  
Time/Place Accident - E. Fordham Rd / Washington Ave  
Policy Report - Yes

Date of Visit - 05/20/2025  
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# - 8775359720000003  
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: \_\_\_\_\_

Chinasha, ("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 5/16/25, not withstanding any other agreement  
(Print accident date)  
to the contrary.

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

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

Chinasha Herbert  
(Print name of Patient)

Chinasha Herbert  
(Signature of Patient)

5/29/2025  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

05/29/2025  
(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.

α Signed: Chinasha herbert Date: 05/29/2025

**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.

α Signed: Chinasha herbert Date: 05/29/2025

**Females: Regarding Possibility of Pregnancy**

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

α Signed: Chinasha herbert Date: 05/29/25

5/28/2025

(01073)-Brown Kisan

Date of Birth - 10/3/1990 Sex - Female Marital Status - Single

Address: 10 South 2nd Avenue #5, Mount Vernon, NY, 10550  
Phone #: (914) 563-9522

Social Security# - - -9422

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 3/14/2025

Time/Place Accident -

Date of Visit - 3/18/2025

Condition Related to : Auto Accident

Insurance Company : Progressive Advanced Insurance Company

Address:

Phone: Fax:

Claim# - 25-455552763

NF-2 - Yes Sending Date - 04/10/2025

Policy Effective Date -

Policy# - 955088844

Policy holder - Addison, Rayshaun, I White, Caria

WCB# -

Carrier case # -

Attorney - Salerno & Goldberg, PC Firm Name - Salerno & Goldberg, PC

Attorney Address - 1955 Deer Park Avenue, NY. 11729

Attorney Phone - 631-482-8888 Fax - 631-482-8889

Contact Person -

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, Kisan ("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.

Kisan Brom  
(Print name of Patient)

[Signature]  
(Signature of Patient)  
5/29/2025  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)  
05/29/2025  
(Date of signature)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301  
(Address of Provider)

**DYNAMIC MOBILE XRAY SERVICES LLC**

**3412 BLUESTONE LANE**

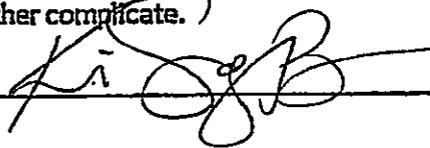
**EAST STROUDSBURG PA 18301**

**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.

X Signed:  Date: 05/29/2025

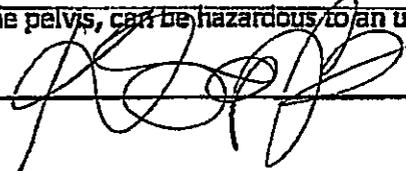
**Consent To X-Ray:**

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.

X Signed:  Date: 05/29/2025

**Females: Regarding Possibility of Pregnancy**

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

X Signed:  Date: 05/29/25

05/29/2025

**(01081)-Moulier Ashley N.**

Date of Birth - 09/29/1993 Sex - Female Marital Status - Single

Address: 2755 Pearsall Ave, Bronx, NY, 10469  
Phone #: (929) 262-9591

Social Security# - - -

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 04/13/2025

Time/Place Accident -

Date of Visit - 04/17/2025

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# - 0295438060101064

NF-2 - Yes Sending Date - 04/30/2025

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Other Insurance -

Medicare -

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

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

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

Ashley N. Moulter ("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 4/13/25, 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 DEFAUD 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.

Ashley N. Moulter  
(Print name of Patient)

Ashley Moulter  
(Signature of Patient)

5/29/2025  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

05/20/2025  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

**DYNAMIC MOBILE XRAY SERVICES LLC**

**3412 BLUESTONE LANE**

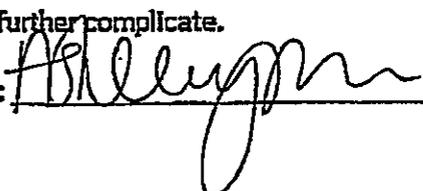
**EAST STROUDSBURG PA 18301**

**Tel: (570) 243-1888**

**X-Ray Consent Form**

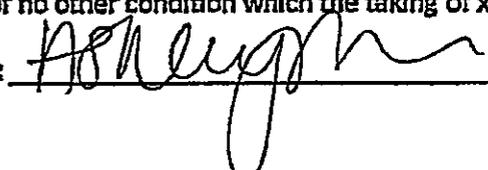
**Parent Consent To X-Ray:**

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.

α Signed:  Date: 05/29/2025

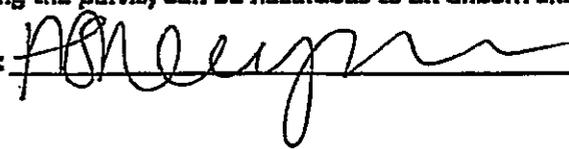
**Consent To X-Ray:**

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.

α Signed:  Date: 05/29/2025

**Females: Regarding Possibility of Pregnancy**

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

α Signed:  Date: 05/29/25

5/28/2025

(01088)-Rosales Diaz Karen

Date of Birth - 1/6/1997 Sex - Female Marital Status - Single

Address: 547 S 10th Avenue, Mount Vernon, NY, 10550  
Phone #: (914) 291-7618

Social Security# - - -6439

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 4/16/2025

Time/Place Accident - North Columbus Avenue / East Prospect Avenue (Westchester)

Policy Report - Yes

Date of Visit - 4/29/2025

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# - 0678193360000002

NF-2 - Yes Sending Date - 05/08/2025

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - Firm Name -

Attorney Address -

Attorney Phone - Fax -

Contact Person -

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, Karen, ("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 04/16/2025, not withstanding any other agreement  
(Print accident date)  
to the contrary.

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

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO 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.

Karen Rosales Diaz  
(Print name of Patient)

Karen Rosales  
(Signature of Patient)

5/29/2025  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

05/29/2025  
(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.

α Signed: *[Signature]* Date: 05/29/2025

**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.

α Signed: *[Signature]* Date: 05/29/2025

**Females: Regarding Possibility of Pregnancy**

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

α Signed: *[Signature]* Date: 05/29/25

5/28/2025

(01087)-Johnson Delaney

Date of Birth - 9/15/1958 Sex - Male Marital Status - Single

Address: 1767 Arnow Avenue #A, Bronx, NY, 10469  
Phone #: (917) 703-7642

Social Security# - - -4134

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 4/26/2025

Time/Place Accident -

Date of Visit - 4/28/2025

Condition Related to : Auto Accident

Insurance Company : Allstate Insurance Co.

Address:

Phone: 800-255-7828 Fax:

Claim# - 0791217755

NF-2 - Yes Sending Date - 05/08/2025

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - Jeffrey A. Aronsky Firm Name - Jeffrey A. Aronsky Attorney At Law .

Attorney Address - 800 Second Ave, Suite 301, NY, NY. 10017

Attorney Phone - 212-577-6600 Fax - 212-577-6776

Contact Person -

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: \_\_\_\_\_

[Signature], ("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 4/26/25, 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 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.

[Signature]  
(Print name of Patient)

[Signature]  
(Signature of Patient)

5/30/2025  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301  
(Address of Provider)

05/30/2025  
(Date of signature)

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

**X-Ray Consent Form**

**Parent Consent To X-Ray:**

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

Signed: [Signature] Date: 05/29/2025

**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: [Signature] Date: 05/29/2025

**Females: Regarding Possibility of Pregnancy**

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

Signed: [Signature] Date: 05/29/25

5/28/2025

(01082)-Bernal Fior

Date of Birth - 9/23/1951 Sex - Female Marital Status - Single

Address: 320 Morris Ave #12E, Bronx, NY, 10451  
Phone #: (347) 942-3529

Social Security# -

Employer or Company Name:  
Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 4/9/2025  
Time/Place Accident - Greylock Pkwy  
Policy Report - Yes

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Date of Visit - 4/21/2025  
Condition Related to : Auto Accident

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Insurance Company : Plymouth Rock Insurance

Address: P.O. BOX 900  
Lincroft, NJ, 07738  
Phone: 844-346-1225 Fax: 732-978-7109

Claim# - 693302584633  
NF-2 - Yes Sending Date - 04/30/2025  
Policy Adjuster - 732-378-4512

F:732-978-7109

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

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

Other Insurance -  
Medicare -

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

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

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

Fiore Bernal ("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 4/8/25, 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.

Fiore Bernal  
(Print name of Patient)

Fiore Bernal  
(Signature of Patient)

5/29/2025  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301  
(Address of Provider)

05/29/2025  
(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: Fior Bernal Date: 05/29/2025

#### 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: Fior Bernal Date: 05/29/2025

#### Females: Regarding Possibility of Pregnancy

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

Signed: Fior Bernal Date: 05/29/25

5/28/2025

(01049)-Johnson Kenneth

Date of Birth - 11/19/1962 Sex - Male Marital Status - Single

Address: 1500 Noble Avenue #10H, Bronx, NY, 10460  
Phone #: (917) 770-6664

Social Security# - - -0472

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 2/6/2025

Time/Place Accident -

Date of Visit - 2/10/2025

Condition Related to : Auto Accident

Insurance Company : Allstate Fire And Casualty Insurance Company

Address: PO BOX 2874  
Clinton, IA, 52733-2874

Phone: Fax:

Claim# - 0783228489

Claim Address - Allstate Fire And Casualty Insurance Company  
PO BOX 2874  
Clinton, IA. 52733

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

Policy Effective Date -

Policy# - 983239926

Policy holder - Johnathan Johnson

WCB# -

Carrier case # -

Attorney - Klafter Law Group Firm Name - Klafter Law Group  
Attorney Address - 36-36 33rd Street, Suite 307, Long Island City, NY. 11106  
Attorney Phone - 718-465-1160 Fax - 646-273-2500  
Contact Person -

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: \_\_\_\_\_

L. KENNEDY No. 1111 ("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 2/6/25, 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.

\_\_\_\_\_  
(Print name of Patient)

[Signature]  
(Signature of Patient)

\_\_\_\_\_

5/29/2025  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

05/29/2025  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

**DYNAMIC MOBILE XRAY SERVICES LLC**

**3412 BLUESTONE LANE**

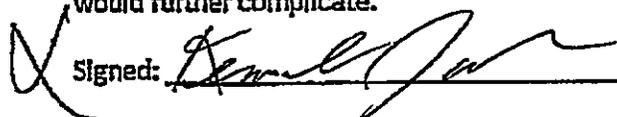
**EAST STROUDSBURG PA 18301**

**Tel: (570) 243-1888**

**X-Ray Consent Form**

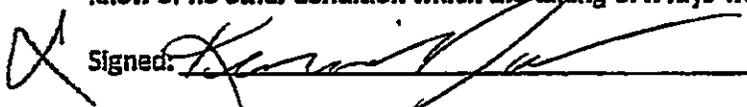
**Parent Consent To X-Ray:**

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: 05/29/2025

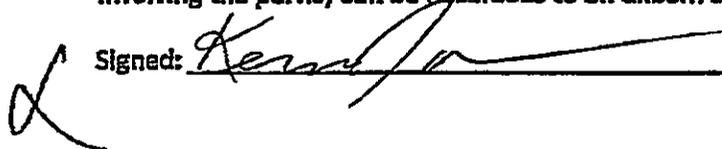
**Consent To X-Ray:**

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: 05/29/2025

**Females: Regarding Possibility of Pregnancy**

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

Signed:  Date: 05/29/25

5/28/2025

**(01086)-Muldrow Monique J.**

Date of Birth - 4/8/1965 Sex - Female Marital Status - Single

Address: 1462 Needham Avenue #4, Bronx, NY, 10469  
Phone #: (646) 904-2331

Social Security# - - -6949

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 4/26/2025

Time/Place Accident -

Date of Visit - 4/28/2025

Condition Related to : Auto Accident

Insurance Company : Allstate Insurance Co.

Address:

Phone: 800-255-7828 Fax:

Claim# - 0791217755

NF-2 - Yes Sending Date - 05/08/2025

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - Jeffrey A. Aronsky Firm Name - Jeffrey A. Aronsky Attorney At Law

Attorney Address - 800 Second Ave, Suite 301, NY, NY. 10017

Attorney Phone - 212-577-6600 Fax - 212-577-6776

Contact Person -

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: \_\_\_\_\_

*Monique Muldra*  
\_\_\_\_\_  
(Print patient's name)

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

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on 4/26/25, 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.

*Monique Muldra*  
\_\_\_\_\_  
(Print name of Patient)

*Monique Muldra*  
\_\_\_\_\_  
(Signature of Patient)  
5/29/2025  
\_\_\_\_\_  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
\_\_\_\_\_  
(Print name of Provider)

*[Signature]*  
\_\_\_\_\_  
(Signature of Provider)  
05/29/2025  
\_\_\_\_\_  
(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: [Signature]

Date: 05/29/2025

**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: [Signature]

Date: 05/29/2025

**Females: Regarding Possibility of Pregnancy**

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

Signed: [Signature]

Date: 05/29/25