

DAILY SIGN IN

*Easter*  
*Admission*

DATE: 06/24/25

PLEASE PRINT NAME

PATIENT NAME	PATIENT NAME
1. <i>Dejous Arkanie</i>	21.
2. <i>Kevin Shebang</i>	22.
3. <i>Bryan Christopher</i>	23.
4. <i>David Joseph</i>	24.
5. <i>Tina Derway</i>	25.
6. <i>Adrian Parker</i>	26.
7.	27.
8.	28.
9.	29.
10.	30.
11.	31.
12.	32.
13.	33.
14.	34.
15.	35.
16.	36.
17.	37.
18.	38.
19.	39.
20.	40.

06/24/2025

**(01094)-De Jesus Arkanie**

Date of Birth - 12/07/1998    Sex - Female    Marital Status - Single

Address: 333 Huguenot Street #P204, New Rochelle, NY, 10801

Phone #: (347) 879-9308

Social Security# - - -6423

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 05/25/2025

Time/Place Accident - 4129 Seton Avenue

Policy Report - Yes

---

Date of Visit - 06/03/2025

Condition Related to : Auto Accident

Insurance Company : State Farm Mutual Automobile Insurance Co.

Address: P.O. Box 106170

Atlanta, GA, 30348-6170

Phone: 800-258-9884    Fax:

Claim# - 3285P627T

Claim Address - State Farm Mutual Automobile Insurance Co.

P.O. Box 106170

Atlanta, GA, 30348

NF-2 - Yes    Sending Date - 06/18/2025

Policy Adjuster - Jennifer Berry 945-219-9393

Policy Effective Date -

Policy# - 346414702332

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, Arkanke Dejesus, ("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 05/25/2025, 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.

Arkanke Dejesus  
(Print name of Patient)

[Signature]  
(Signature of Patient)

333 HUGUENOT STREET APT

06/24/2024  
(Date of signature)

P204 NEW ROCHELLE, NY 10801  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

06/24/25  
(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: Am Depina Date: 06/24/25

**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: 06/24/25

**Females: Regarding Possibility of Pregnancy**

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

Signed: Am Depina Date: 06/24/25

06/24/2025

**(01069)-Azwim Shabana**

Date of Birth - 06/27/1991    Sex - Female    Marital Status - Single

Address: 875 East 175th Street #2, Bronx, NY, 10460  
Phone #: (929) 282-7903

Social Security# - - -2027

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 03/03/2025

Time/Place Accident - Grand Concourse between 162nd Street and 163rd Street

Date of Visit - 03/06/2025

Condition Related to : Auto Accident

Insurance Company : MTA

Address:

Phone:    Fax:

Claim# - BU202503030006-001

Claim Address - MTA  
2 Broadway, 21st Floor  
New York, NY. 10004

NF-2 - Yes    Sending Date - 04/23/2025

Policy Adjuster - 718-694-4646

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, Shabana Azwiri ("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 3/3/25, 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.

Shabana Azwiri  
(Print name of Patient)

[Signature]  
(Signature of Patient)  
6/24/25  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)  
06/24/25  
(Date of signature)

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

**DYNAMIC MOBILE XRAY SERVICES LLC**

**3412 BLUESTONE LANE**

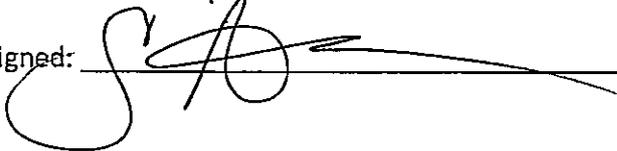
**EAST STROUDSBURG PA 18301**

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

**X-Ray Consent Form**

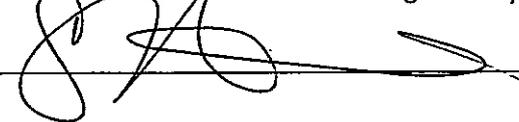
**Parent Consent To X-Ray:**

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

Signed:  Date: 06/24/25

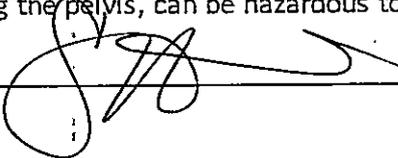
**Consent To X-Ray:**

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: 06/24/25

**Females: Regarding Possibility of Pregnancy**

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

Signed:  Date: 06/24/25

06/24/2025

**(01092)-Bryan Christopher R.**

Date of Birth - 08/03/1987   Sex - Male   Marital Status - Single

Address: 27 Harper Court, Bronx, NY, 10466

Phone #: (347) 652-3177

Social Security# -

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 05/14/2025

Time/Place Accident - Grand Concourse & East 144th Street

Policy Report - Yes

Date of Visit - 05/21/2025

Condition Related to : Auto Accident

Insurance Company : Progressive Advanced Insurance Company

Address:

Phone:   Fax:

Claim# - 25-950637461

NF-2 - Yes   Sending Date - 06/11/2025

Policy Adjuster - Kelly H.

Policy Effective Date -

Policy# - 943184447

Policy holder - Jackson Paula

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, Chris Bran, ("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.

Chris Bran  
(Print name of Patient)

[Signature]  
(Signature of Patient)  
6-24-25  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)  
06/24/25  
(Date of signature)

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

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

### X-Ray Consent Form

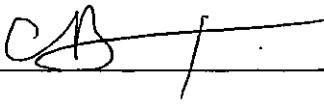
#### Parent Consent To X-Ray:

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

Signed:  Date: 06/24/25

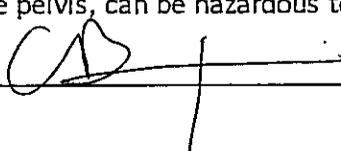
#### Consent To X-Ray:

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: 06/24/25

#### Females: Regarding Possibility of Pregnancy

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

Signed:  Date: 06/24/25

**(01096)-Asare Joseph M.**

Date of Birth - 08/06/1957 Sex - Male Marital Status - Single

Address: 70 Hawthorne Avenue # C624, Yonkers, NY, 10701  
Phone #: (914) 707-9262

Social Security# - - -0201

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 05/13/2025

Time/Place Accident - Yonkers Avenue / Prescott Street (Yonkers)

Policy Report - Yes

Date of Visit - 05/27/2025

Condition Related to: Auto Accident

Insurance Company : Maya Assurance Company

Address: PO BOX 1896

Long Island City, NY, 11101

Phone: 718-937-2010 Fax:

Claim# - 2-253473-N01

NF-2 - Yes Sending Date - 06/18/2025

Policy Effective Date -

Policy# -

Policy holder - Asare, Joseph 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, Joseph Asare, ("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.

Joseph Asare  
(Print name of Patient)

[Signature]  
(Signature of Patient)

6/24/25  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

06/24/25  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

**DYNAMIC MOBILE XRAY SERVICES LLC**

**3412 BLUESTONE LANE**

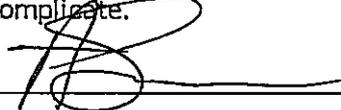
**EAST STROUDSBURG PA 18301**

**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: 06/24/25

**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: 06/24/25

**Females: Regarding Possibility of Pregnancy**

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

Signed: \_\_\_\_\_ Date: 06/24/25

06/24/2025

**(01084)-Turner Dontayisa**

Date of Birth - 11/23/1991 Sex - Female Marital Status - Single

Address: 1057 Boynton Avenue #4G, Bronx, NY, 10472

Phone #: (347) 261-8509

Social Security# - - -4071

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 04/03/2025

Time/Place Accident - 1866 Bronxdale Avenue

Policy Report - Yes

Date of Visit - 04/23/2025

Condition Related to : Job

Insurance Company : Hereford Insurance Company

Address: 36-01 43rd Avenue 2nd FLR

Long Island City, NY, 11101-4314

Phone: 718-361-1221 Fax: 718-559-3460

Claim# -

NF-2 - No

Policy Effective Date -

Policy# - PAM1378995-0

Policy holder - Massive Transportation INC

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: \_\_\_\_\_

41 Donta Lisa Turner ("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 4/3/25, 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.

Donta Lisa Turner  
(Print name of Patient)

Donta Lisa Turner  
(Signature of Patient)

4/24/2025  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

06/24/25  
(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: D. [Signature] Date: 06/24/25

#### 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: D. [Signature] Date: 06/24/25

#### Females: Regarding Possibility of Pregnancy

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

Signed: D. [Signature] Date: 06/24/25

06/24/2025

**(01080)-Gedeon Patrick**

Date of Birth - 09/12/1979 Sex - Male Marital Status - Single

Address: 21 Birch Street #1, New Rochelle, NY, 10801

Phone #: (347) 488-4795

Social Security# - - -6887

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 04/11/2025

Time/Place Accident -

Date of Visit - 04/15/2025

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# - 8849117170000001

Claim Address - GEICO Indemnity Co.

P.O. Box 9507

Fredericksburg, VA. 22403

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

Policy Adjuster - Roydel Morris 516-496-5146

Policy Effective Date -

Policy# - 6200739255

Policy holder - Patrick Gedeon

WCB# -

Carrier case # -

Other Insurance -

Medicare -

---

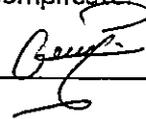


DYNAMIC MOBILE XRAY SERVICES LLC  
3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301  
Tel: (570) 243-1888

**X-Ray Consent Form**

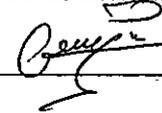
**Parent Consent To X-Ray:**

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: 06/24/25

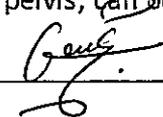
**Consent To X-Ray:**

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: 06/24/25

**Females: Regarding Possibility of Pregnancy**

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

Signed:  Date: 06/24/25