Eastlake Avenue

DAILY SIGN IN

DATE: 06/24/25

PLEASE PRINT NAME

PATIENT NAME	PATIENT NAME
1. Dejasus Arkanie	21.
2. Steven ghabang	22.
3. Bryan Christopher	23.
4. Mao Joseph	24.
5. Tune Lowayesq	25.
6. Gedeon patine	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, Arcante 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.

Arcante Dejesus
(Print name of Patient)

(Signature of Patient)

333 Huguenot Street APT
P204 New Rochelle, NY 10801
(Address of Patient)

06/24/2024
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

(Signature of Provider)

3412 BLUESTONE LANE

06/24/25
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

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: 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.

X 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.

X Signed: _____ 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 Azwin ("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 Azwin
(Print name of Patient)

(Signature of Patient)

6/24/25
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

(Signature of Provider)

3412 BLUESTONE LANE

06/24/25
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

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: 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.

X 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.

X 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 Byan, ("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 Byan
(Print name of Patient)

Chris Byan
(Signature of Patient)

6-24-25
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

(Signature of Provider)

06/24/25
(Date of signature)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

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: 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.

X 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.

X Signed: _____ Date: 06/24/25

06/24/2025

(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, _____ (Print patient's name), ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS (Print hospital or health care provider name), ("Assignee") 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 _____ (Print accident date), not withstanding any other agreement 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 A Sare
(Print name of Patient)

(Signature of Patient)

6/24/25
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

(Signature of Provider)

06/24/25
(Date of signature)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

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: 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.

X 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.

X 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: _____

I, Dontaysa 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.

Dontaysa Turner
(Print name of Patient)

(Signature of Patient)

6/24/2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

(Signature of Provider)

3412 BLUESTONE LANE

06/24/25
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

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: 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.

X 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.

X 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 -

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.

Guy P. _____ 06/24/2025 Guy P. _____
(Print name of Patient) (Signature of Patient)

_____ 06/24/25 _____
(Date of signature)

_____
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES _____
(Print name of Provider) (Signature of Provider)

3412 BLUESTONE LANE 06/24/25
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

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: 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.

X 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.

X Signed: _____ Date: 06/24/25