

DAILY SIGN IN

2354
Westchester

DATE: 9/17/25

Extremity log sheet

PLEASE PRINT NAME

PATIENT NAME		PATIENT NAME	
1.	Victoriano Elmer	21.	
2.	Ocasio Indayross	22.	
3.	Abreu marilyn	23.	
4.	fuentes Ashley	24.	
5.	Soto Katelyn	25.	
6.	Belle Melo gemma	26.	
7.	Gutierrez Amara	27.	
8.	Rodriguez Leticia	28.	
9.	Rodriguez Velazquez	29.	
10.		30.	
11.		31.	
12.		32.	
13.		33.	
14.		34.	
15.		35.	
16.		36.	
17.		37.	
18.		38.	
19.		39.	
20.		40.	

PATIENT DEMOGRAPHIC FORM 09/17/2025

VICTORIANO, ELIVER

DOB: 05/24/1998

Cell Phone: 929-300-8500

Sex: Male

Home phone:

DOA: 08/28/2025

Social Security Number:

Case type: No Fault

Address: 212 W KINGSBRIDGE APT 1C, Bronx, NY, 10463

Primary Insurance: STATE FARM INS

Address: PO BOX 106170, Atlanta, GA, 30348

Claim Number: 3290D584D

Policy Number: 32-9E15-N66

Policy Holder: VICTORIANO, ELIVER

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: ALEXANDER BESPECHNY

Address: 2360 WESTCHESTER AVENUE, Bronx, NY, 10462

Phone number: 718-792-4800

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office: 2354 Chiropractic PC

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

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

Claim Number: _____

X I, Eliver victoriano Rodriguez, ("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.

X Eliver victoriano Rodriguez
(Print name of Patient)

X Eliver victoriano Rodriguez
(Signature of Patient)

(Address of Patient)

X 09/17/20
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

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

09/17/2025
(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.

X Signed: Elieir Victoriano Rodriguez Date: 09/17/25

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: Elieir Victoriano Rodriguez Date: 09/17/25

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: Elieir Victoriano Rodriguez Date: 09/17/25



MOBILE PORTABLE X-RAY ORDER FORM

DATE 09/17/28

YOUR INFORMATION:

NAME Victoriano-Rodriguez Eliver D.O.B. 5/24/98 SS# _____ MALE FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____ - _____

FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE NAME _____ INSURANCE ID # _____

SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES Complete 3 or more views <input type="checkbox"/> 70150</p> <p>FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views <input type="checkbox"/> 70360</p> <p>ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p>SI JOINTS Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views <input type="checkbox"/> 71120</p> <p>THORACIC 3 views <input checked="" type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY</p> <p>EXTREMITY Lower. 2 views <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS min. 2 views <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME Scarborough D.C NPI# _____ FAX RESULTS TO () _____

INDICATE REASON FOR STUDY No Pathology + Fracture SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN _____ TECHNIQUE _____ # OF VIEWS _____

X-RAY SENT TO RADIOLOGIST _____ DATE X-RAY SENT / / PATIENT ID # _____ # OF CD _____

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

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: VICTORIANO ELIVER

DATE OF BIRTH: 05/24/1998

ID/MRN: 20250917170510188

CLINICIAN: SCARBOROUGH, PAUL. DR

FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC

DATE OF EXAM: 09/17/2025

HISTORY: R/O PATHOLOGY/M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER

SPINE THORACIC X-RAY 2 view:

DORSAL SPINE: The dorsal vertebrae are in normal alignment. There is no evidence for bony erosion or destruction. There is no evidence for fracture or dislocation.

IMPRESSION:

Negative dorsal spine.

RIGHT SHOULDER X-Ray Complete 2 or more views:

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

IMPRESSION:

Negative right shoulder.

Electronically Signed By: Steven Brownstein MD 09/17/2025 21:15:04 EDT

Tech: Dynamic Mobile Xray Services LLC

PATIENT DEMOGRAPHIC FORM 09/17/2025

OCASIO, MILAGROS

DOB: 10/15/1973

Cell Phone: 646-474-8472

Sex: Female

Home phone:

DOA: 07/21/2025

Social Security Number:

Case type: No Fault

Address: 1018 E 163RD STREET APT 4L, Bronx, NY, 10459

Primary Insurance: GEICO

Address: P.O. BOX 9507, Fredericksburg, VA, 22403

Claim Number: 0455051840101052

Policy Number: 4280826621

Policy Holder: OCASIO, MILAGROS

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: STRATFORD LAW GROUP

Address: 69 STRATFORD ROAD FLOOR 2ND FLOOR, Brooklyn, NY, 11218

Phone number: 718-450-3909

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

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

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

Claim Number: _____

X Milagros Ocasio ("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 7-21-2005, 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.

X Milagros Ocasio
(Print name of Patient)

X Milagros Ocasio
(Signature of Patient)

(Address of Patient)

X 9/17/2005
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

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

09/17/25
(Date of signature)

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

X-Ray Consent Form

Parent Consent To X-Ray:

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

X Signed: *[Signature]* Date: 9/17/2025

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: *[Signature]* Date: 9/17/2025

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: *[Signature]* Date: 9/17/2025



DYNAMIC
MOBILE XRAY SERVICES LLC

Phone: (570)243-1888

Fax: 570-209-5771

Email: dynamicmobilexrays@gmail.com

website: dynamjcmobilexray.com

MOBILE PORTABLE X-RAY ORDER FORM

DATE 9/17/20

YOUR INFORMATION:

NAME Ocasio, Milagros D.O.B. 06/16/73 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE (____) _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY .. Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES.. Complete 3 or more views..... <input type="checkbox"/> 70150</p> <p>FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES .. Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views <input type="checkbox"/> 70360</p> <p>ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71107 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views -R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p>SI JOINTS Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views <input type="checkbox"/> 71120</p> <p>THORACIC 3 views <input checked="" type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY</p> <p>EXTREMITY Lower. 2 views <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS .. min. 2 views <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME SCARONIA D.C. NPI# _____ FAX RESULTS TO _____
 INDICATE REASON FOR STUDY R/O PATH / ED SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN _____ TECHNIQUE _____ # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST _____ DATE X-RAY SENT ____ / ____ / ____ PATIENT ID # _____ # OF CD _____

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

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

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: OCASIO MILAGROS**DATE OF BIRTH:** 10/15/1973**ID/MRN:** 20250917162823887**CLINICIAN:** SCARBOROUGH, PAUL. DR**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC**DATE OF EXAM:** 09/17/2025**HISTORY:** R/O PATHOLOGY M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER, M25.561-PAIN IN RIGHT KNEE

SPINE THORACIC X-RAY 2 view:

Technique: Thoracic spine, 2 views

Comparison: None.

Findings: There is normal alignment of thoracic spine with no subluxation. There are no compression deformities. The bony mineralization is mildly decreased. Moderate narrowing of intervertebral disc spaces with spurring.

IMPRESSION:

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

RIGHT SHOULDER X-Ray Complete 2 or more views:

Technique: Right Shoulder, 2 views

Comparison: None.

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

IMPRESSION:

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

RIGHT KNEE X-Ray - 3 view:

Technique: Right knee, 3 views

Comparison: None.

Findings: No radiographic evidence of acute fracture or dislocation. The patella, distal femur, proximal tibia and fibula are intact. There is no deep sulcus sign to suggest anterior cruciate ligament tear. The bony mineralization is mildly decreased. There is no joint effusion. Moderate narrowing of the medial and patella-femoral joint spaces.

IMPRESSION:

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

Electronically Signed By: Dr. Naiyer Imam M.D. 09/17/2025 21:37:36 EDT

Tech: Dynamic Mobile Xray Services LLC

PATIENT DEMOGRAPHIC FORM 09/17/2025

ABREU, MARELYN

DOB: 08/28/1987

Cell Phone: 347-584-3312

Sex: Female

Home phone:

DOA: 08/09/2025

Social Security Number: 596-14-7130

Case type: No Fault

Address: 512 CHESTER AVE, Roselle Park, NJ, 07204

Primary Insurance: PROGRESSIVE INS

Address: 725 BROADWAY, Albany, NY, 12207

Claim Number: 25-854846108

Policy Number: 971307313

Policy Holder: ABREU, MARELYN

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney:

Address:

Phone number:

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

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

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

Claim Number: _____

X I, Marelyn Abreu, ("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 8/9/25, 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.

X Marelyn abreu
(Print name of Patient)

512 Chester ave

Rosellepark NJ 07204
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301
(Address of Provider)

X Marelyn Abreu
(Signature of Patient)

X 09-17-25
(Date of signature)

[Signature]
(Signature of Provider)

09/17/25
(Date of signature)

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

X-Ray Consent Form

Parent Consent To X-Ray:

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

X Signed: Ma. Paul Date: 9-17-25

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: Ma. Paul Date: 9/17/25

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: Ma. Paul Date: 9/17/25



MOBILE PORTABLE X-RAY ORDER FORM

DATE 9/17/20

YOUR INFORMATION:

NAME ABREW, MARELYN D.O.B. 8/28/87 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE (____) _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN XUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY .. Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES .. Complete 3 or more views <input type="checkbox"/> 70150</p> <p>FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND Complete 3 views - R <input type="checkbox"/> <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES .. Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views <input type="checkbox"/> 70360</p> <p>ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views -R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input type="checkbox"/> L <input checked="" type="checkbox"/> 73030</p> <p>SI JOINTS Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views <input type="checkbox"/> 71120</p> <p>THORACIC 3 views <input checked="" type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY</p> <p>EXTREMITY Lower. 2 views <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS .. min. 2 views <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME SCARBOROUGH NPI# _____ FAX RESULTS TO (____) _____
 INDICATE REASON FOR STUDY R/O Pathology / FX SIGNATURE [Signature]

FOR OFFICE USE ONLY:

TECHNICIAN _____ TECHNIQUE _____ # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST _____ DATE X-RAY SENT ____ / ____ / ____ PATIENT ID # _____ # OF CD _____

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

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: ABREU MARELYN
DATE OF BIRTH: 08/28/1987
ID/MRN: 20250917150833759
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 09/17/2025
HISTORY: R/O PATHOLOGY M54.6-PAIN IN THORACIC SPINE, M25.512-PAIN IN LEFT SHOULDER

SPINE THORACIC X-RAY 2 view:

DORSAL SPINE: The dorsal vertebrae are in normal alignment. There is no evidence for bony erosion or destruction. There is no evidence for fracture or dislocation. Tilt of the thoracic column to left noted.

IMPRESSION:

Negative dorsal spine.

LEFT SHOULDER X-Ray Complete 2 or more views:

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

IMPRESSION:

Negative left shoulder.

Electronically Signed By: Steven Brownstein MD 09/17/2025 20:30:46 EDT

Tech: Dynamic Mobile Xray Services LLC

PATIENT DEMOGRAPHIC FORM 09/17/2025

SOTO, KATELYN

DOB: 03/21/2002

Cell Phone: 347-601-1146

Sex: Female

Home phone:

DOA: 07/21/2025

Social Security Number: 058-92-6748

Case type: No Fault

Address: 1018 E 163RD STREET APT 4L, Bronx, NY, 10459

Primary Insurance: GEICO

Address: P.O. BOX 9507, Fredericksburg, VA, 22403

Claim Number: 0455051840101052

Policy Number: 4280826621

Policy Holder: OCASIO, MILAGROS

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: ALMONTE LITIGATION GROUP

Address: 69 Stratford Rd. 2nd Fl, Brooklyn, NY, 11218

Phone number: 718-450-3909

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: SOTO KATELYN
DATE OF BIRTH: 03/21/2002
ID/MRN: 20250917141045320
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 09/17/2025
HISTORY: M25.512-PAIN IN LEFT SHOULDER

LEFT SHOULDER X-Ray Complete 2 or more views:

Findings:

The gleno-humeral joint is intact. Acromioclavicular and coracoclavicular joints are also normal. There is no shoulder separation, fracture or dislocation.

IMPRESSION:

Normal left shoulder.

Electronically Signed By: Jason Liu, MD 09/17/2025 17:43:32 EDT

Tech: Dynamic Mobile Xray Services LLC

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

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

Claim Number: _____

X I, Katelin Soto ("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 7/21/25, 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.

X Katelyn Soto
(Print name of Patient)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301
(Address of Provider)

X Katelin Soto
(Signature of Patient)

X 9/17/25
(Date of signature)

[Signature]
(Signature of Provider)

09/17/25
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

Parent Consent To X-Ray:

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

X Signed: Katerin Set Date: 9/17/25

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: Katerin Set Date: 9/17/25

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: Katerin Set Date: 9/17/25



DYNAMIC
MOBILE XRAY SERVICES LLC

Phone: (570)243-1888

Fax: 570-209-5771

Email: dynamicmobilexrays@gmail.com

website: dynamjcmobilexray.com

MOBILE PORTABLE X-RAY ORDER FORM

DATE 9/17/25

YOUR INFORMATION:

NAME SOTO, Katelyn D.O.B. 7/21/25 SS# _____ MALE FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE (____) _____

FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE NAME _____ INSURANCE ID # _____

SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY .. Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES .. Complete 3 or more views <input type="checkbox"/> 70150</p> <p>FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES .. Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views <input type="checkbox"/> 70360</p> <p>ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input type="checkbox"/> L <input checked="" type="checkbox"/> 73030</p> <p>SI JOINTS Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views <input type="checkbox"/> 71120</p> <p>THORACIC 3 views <input type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY</p> <p>EXTREMITY Lower. 2 views <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS .. min. 2 views <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME Scarborough D.C. NPI# 1649289547 FAX RESULTS TO _____

INDICATE REASON FOR STUDY NO pathology + fix SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN _____ TECHNIQUE _____ # OF VIEWS _____

X-RAY SENT TO RADIOLOGIST _____ DATE X-RAY SENT / / PATIENT ID # _____ # OF CD _____

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

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

PATIENT DEMOGRAPHIC FORM 09/17/2025

BELTRE-MELO, GENESIS

DOB: 02/12/1988

Cell Phone: 929-645-8114

Sex: Male

Home phone:

DOA: 07/16/2025

Social Security Number:

Case type: No Fault

Address: 1014 HOE AVE, Bronx, NY, 10459

Primary Insurance: BRISTOL WEST INSURANCE COMPANY

Address: PO BOX 258807, Oklahoma City, OK, 73125

Claim Number: 7009200993-1

Policy Number:

Policy Holder: ELIAS-ACOSTA, IZULEYMA

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: Lozner & Mastropietro Law Office

Address: 1901 Emmons Ave, Suite #206, Brooklyn, NY, 11235

Phone number: 718-615-0044

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office: 2354 Chiropractic PC

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: BELTRE-MELO GENESI
DATE OF BIRTH: 02/12/1988
ID/MRN: 20250917125437914
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 09/17/2025
HISTORY: R/O PATHOLOGY M54.6-PAIN IN THORACIC SPINE, M25.512-PAIN IN LEFT SHOULDER

SPINE THORACIC X-RAY 2 view:

Comparison: None

FINDINGS:

Multiple views of the thoracic spine demonstrate normal alignment.
There are no acute fractures or subluxations of the thoracic spine.
The vertebral body heights and disc spaces are grossly preserved.
The soft tissues are unremarkable.

If there is further concern or neurological abnormalities on clinical exam, recommend further radiographic views, MRI or CT of the thoracic spine for complete assessment.

IMPRESSION:

No acute fracture or subluxation of the thoracic spine.

LEFT SHOULDER X-Ray Complete 2 or more views:

Comparison: None

FINDINGS:

Multiple views of the left shoulder show normal alignment at the gleno-humeral joint.
There are no acute fractures or dislocations.
The acromioclavicular joint and coracoclavicular spaces are intact.
The visualized scapula and clavicle are unremarkable.

There are no radiopaque foreign bodies.

No soft tissue swelling is seen.

If there is further concern, follow-up radiographs or MRI of the shoulder may be performed for complete assessment.

IMPRESSION:

No acute fracture or dislocation of left shoulder.

Electronically Signed By: Dr. Lan Vu M.D. 09/17/2025 16:58:19 EDT

Tech: Dynamic Mobile Xray Services LLC

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

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

Claim Number: _____

X I, Genesia, ("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 7-16-2025, not withstanding any other agreement
(Print accident date)
to the contrary.

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of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

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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.

X Genesia
(Print name of Patient)

X [Signature]
(Signature of Patient)

(Address of Patient)

X 9-17-2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

09/17/25
(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.

X Signed: [Signature] Date: 9-17-2025

Consent To X-Ray:

A Minor I am a parent or legal guardian of _____
who is a minor, 32 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: [Signature] Date: 9-17-2025

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: [Signature] Date: 9-17-2025



DYNAMIC
MOBILE XRAY SERVICES LLC

Phone: (570)243-1888

Fax: 570-209-5771

Email: dynamicmobilexrays@gmail.com

website: dynamicmobilexray.com

MOBILE PORTABLE X-RAY ORDER FORM

DATE 9/22/20

YOUR INFORMATION:

NAME Beltle - Melo D.O.B. 2/12/88 SS# _____ MALE FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____

FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE NAME _____ INSURANCE ID # _____

SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY .. Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/ardotic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES .. Complete 3 or more views <input type="checkbox"/> 70150</p> <p>FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES .. Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views <input type="checkbox"/> 70360</p> <p>ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p>SI JOINTS Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views <input type="checkbox"/> 71120</p> <p>THORACIC 2 views <input checked="" type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY</p> <p>EXTREMITY Lower. 2 views <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS .. min. 2 views <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME P. Scarborough, D.C. NPI# _____ FAX RESULTS TO# _____

INDICATE REASON FOR STUDY Ho Path Hvl 49 up / Fracture SIGNATURE

FOR OFFICE USE ONLY:

TECHNICIAN _____ TECHNIQUE _____ # OF VIEWS _____

X-RAY SENT TO RADIOLOGIST _____ DATE X-RAY SENT / / PATIENT ID # _____ # OF CD _____

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

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

PATIENT DEMOGRAPHIC FORM 09/17/2025

RODRIGUEZ, VALERIA

DOB: 03/06/1988

Cell Phone: 347-341-9849

Sex: Female

Home phone:

DOA: 08/28/2025

Social Security Number:

Case type: No Fault

Address: 212 W KINGSBRIDGE APT 1C, Bronx, NY, 10463

Primary Insurance: STATE FARM INS

Address: PO BOX 106170, Atlanta, GA, 30348

Claim Number: 3290D584D

Policy Number: 32-9E15-N66

Policy Holder: RODRIGUEZ, VALERIA

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: ALEXANDER BESPECHNY

Address: 2360 WESTCHESTER AVENUE, Bronx, NY, 10462

Phone number: 718-792-4800

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office: 2354 Chiropractic PC

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: RODRIGUEZ VALERIA
DATE OF BIRTH: 03/06/1988
ID/MRN: 20250917110822252
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 09/17/2025
HISTORY: R/O PATHOLOGY/ M25.511-PAIN IN RIGHT SHOULDER, M25.512-PAIN IN LEFT SHOULDER, M25.562-PAIN IN LEFT KNEE

LEFT SHOULDER X-Ray Complete 2 or more views:

COMPARISON:
None
BONES:
No acute fracture or concerning focal osseous lesion.
JOINTS:
No dislocation. The joint spaces are normal.
SOFT TISSUES:
The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

RIGHT SHOULDER X-Ray Complete 2 or more views:

COMPARISON:
None
BONES:
No acute fracture or concerning focal osseous lesion.
JOINTS:
No dislocation. The joint spaces are normal.
SOFT TISSUES:
The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

LEFT KNEE X-Ray - 3 view:

COMPARISON:
None
BONES:
No acute fracture or concerning focal osseous lesion.
JOINTS:
No dislocation. The joint spaces are normal.
SOFT TISSUES:
The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

Electronically Signed By: Dr. Asif Anwar M.D. 09/17/2025 12:14:10 EDT

Tech: Dynamic Mobile Xray Services LLC

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

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

Claim Number: _____

X I, Valencia Rodriguez, ("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 8-28-25, 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.

X Valencia Rodriguez
(Print name of Patient)

X Valencia Rodriguez
(Signature of Patient)

(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

09/17/25
(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.

X Signed: Valeri Rodley Date: 9-17-25

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: Valeri Rodley Date: 9-17-25

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: Valeri Rodley Date: 9-17-25



MOBILE PORTABLE X-RAY ORDER FORM

DATE 9.17.25

YOUR INFORMATION:

NAME Rodriguez, Walter D.O.B. 3/6/88 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____ - _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022	HAND Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130 HEEL Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650 HIP Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520	SACRUM & COCCYX . Min. 3 views <input type="checkbox"/> 72220 SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010 SC JOINTS 3 views <input type="checkbox"/> 71130 SHOULDER Complete, 2 views - R <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> 73030
AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050	HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060 KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input checked="" type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565	SI JOINTS Complete, 2 views <input type="checkbox"/> 72200 SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220
ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610	LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views <input type="checkbox"/> 72120	SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260
BONE AGE 1 view <input type="checkbox"/> 77072	MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110	STERNUM Complete 2 views <input type="checkbox"/> 71120
BONE SURVEY Complete <input type="checkbox"/> 77075	MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130	THORACIC 3 views <input type="checkbox"/> 72072
CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052	NASAL BONES Comp. min. 3 views <input type="checkbox"/> 70160	THORACOLUMBAR . 2 views <input type="checkbox"/> 72080
CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035	NECK Soft tissue 2 views <input type="checkbox"/> 70360	TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590
CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000	ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030	TMJ Bilateral open/closed <input type="checkbox"/> 70330
ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080	PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170	TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660
FACIAL BONES Complete 3 or more views <input type="checkbox"/> 70150	RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111	WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110
FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550		INFANT X-RAY
FINGER(S) # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140		EXTREMITY Lower . 2 views <input type="checkbox"/> 73592
FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630		EXTREMITY Upper . 2 views <input type="checkbox"/> 73092
FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090		PELVIS & HIPS min. 2 views <input type="checkbox"/> 73540
		WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100
		OTHER _____

REQUESTING PHYSICIAN:

NAME Dr. Scarborough D.C. NPI# _____ FAX RESULTS TO () _____
 INDICATE REASON FOR STUDY R/O pathology/rx SIGNATURE [Signature]

FOR OFFICE USE ONLY:

TECHNICIAN _____ TECHNIQUE _____ # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST _____ DATE X-RAY SENT ____ / ____ / ____ PATIENT ID # _____ # OF CD _____

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

PATIENT DEMOGRAPHIC FORM 09/17/2025

RODRIGUEZ, LILIAN

DOB: 07/11/1989

Cell Phone: 347-664-0347

Sex: Female

Home phone:

DOA: 08/28/2025

Social Security Number:

Case type: No Fault

Address: 212 W KINGSBRIDGE APT 1C, Bronx, NY, 10463

Primary Insurance: STATE FARM INS

Address: PO BOX 106170, Atlanta, GA, 30348

Claim Number: 3290D584D

Policy Number: 32-9E15-N66

Policy Holder: RODRIGUEZ, LILIAN

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: ALEXANDER BESPECHNY

Address: 2360 WESTCHESTER AVENUE, Bronx, NY, 10462

Phone number: 718-792-4800

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office: 2354 Chiropractic PC

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

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

Claim Number: _____

X Lilian Rodriguez ("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.

X Lilian Rodriguez
(Print name of Patient)

X Lilian Rodriguez
(Signature of Patient)

(Address of Patient)

X _____
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

09/17/25
(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.

X Signed: Lilian Rodriguez Date: 9/17/25

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: Lilian Rodriguez Date: 9/17/25

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: Lilian Rodriguez Date: 9/17/25



DYNAMIC
MOBILE XRAY SERVICES LLC

Phone: (570)243-1888

Fax: 570-209-5771

Email: dynamicmobilexrays@gmail.com

website: dynamjcmobilexray.com

MOBILE PORTABLE X-RAY ORDER FORM

DATE 9/17/20

YOUR INFORMATION:

NAME Rodriguez, Liliaw D.O.B. 2/11/89 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022	HAND Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130 HEEL Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650 HIP Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520 HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060 KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565	SACRUM & COCCYX . Min. 3 views <input type="checkbox"/> 72220 SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010 SC JOINTS 3 views <input type="checkbox"/> 71130 SHOULDER Complete, 2 views - R <input type="checkbox"/> L <input checked="" type="checkbox"/> 73030 SI JOINTS Complete, 2 views <input type="checkbox"/> 72200 SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220 SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260 STERNUM Complete 2 views <input type="checkbox"/> 71120 THORACIC 3 views <input type="checkbox"/> 72072 THORACOLUMBAR . 2 views <input type="checkbox"/> 72080 TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590 TMJ Bilateral open/closed <input type="checkbox"/> 70330 TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660 WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110
AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050	LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views <input type="checkbox"/> 72120	INFANT X-RAY EXTREMITY Lower . 2 views <input type="checkbox"/> 73592 EXTREMITY Upper . 2 views <input type="checkbox"/> 73092 PELVIS & HIPS . . min. 2 views <input type="checkbox"/> 73540 WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100 OTHER _____
ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610	MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110	
BONE AGE 1 view <input type="checkbox"/> 77072	MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130	
BONE SURVEY . . Complete <input type="checkbox"/> 77075	NASAL BONES . . Comp. min. 3 views <input type="checkbox"/> 70160	
CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052	NECK Soft tissue 2 views <input type="checkbox"/> 70360	
CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035	ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030	
CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000	PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170	
ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080	RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111	
FACIAL BONES . . Complete 3 or more views <input type="checkbox"/> 70150		
FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550		
FINGER(S) # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140		
FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630		
FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090		

REQUESTING PHYSICIAN:

NAME P. Scarborough D.C. NPI# _____ FAX RESULTS TO () _____
 INDICATE REASON FOR STUDY No Pathology + Fx SIGNATURE [Signature]

FOR OFFICE USE ONLY:

TECHNICIAN _____ TECHNIQUE _____ # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST _____ DATE X-RAY SENT ____ / ____ / ____ PATIENT ID # _____ # OF CD _____

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

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

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: RODRIGUEZ LILIAN
DATE OF BIRTH: 07/11/1989
ID/MRN: 20250917110652096
CLINICIAN: SCARBOROUGH, PAUL, DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 09/17/2025
HISTORY: R/O PATHOLOGY/M25.511-PAIN IN RIGHT SHOULDER, M25.562-PAIN IN LEFT KNEE

LEFT SHOULDER X-Ray Complete 2 or more views:

COMPARISON:
None
BONES:
No acute fracture or concerning focal osseous lesion.
JOINTS:
No dislocation. The joint spaces are normal.
SOFT TISSUES:
The soft tissues are unremarkable.

IMPRESSION:

**No acute osseous process.
Evaluation is limited by motion artifact.**

LEFT KNEE X-Ray - 3 view:

COMPARISON:
None
BONES:
No acute fracture or concerning focal osseous lesion.
JOINTS:
No dislocation. The joint spaces are normal.
SOFT TISSUES:
The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

Electronically Signed By: Dr. Asif Anwar M.D. 09/17/2025 12:19:06 EDT

Tech: Dynamic Mobile Xray Services LLC

PATIENT DEMOGRAPHIC FORM 09/17/2025

FUENTES, ASHLEY

DOB: 03/07/2003

Cell Phone: 929-504-0028

Sex: Female

Home phone:

DOA: 05/12/2024

Social Security Number: 100-92-8079

Case type: No Fault

Address: 2006 ELLIS AVENUE APT 3D, Bronx, NY, 10472

Primary Insurance: GEICO

Address: P.O. BOX 9507, Fredericksburg, VA, 22403

Claim Number: 0455051840101048

Policy Number: 4280826621

Policy Holder: FUENTES, ASHLEY

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance: MVAIC

Address: 100 WILLIAMS STR 14 FL, New York City, NY, 10038

Claim Number:

Policy Number:

Policy Holder: FUENTES, ASHLEY

Phone Number:

Fax:

BI Attorney: ALEXANDER BESPECHNY

Address: 2360 WESTCHESTER AVENUE, Bronx, NY, 10462

Phone number: 718-792-4800

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

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

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

Claim Number: _____

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

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

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

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

X Ashley Fuentes
(Print name of Patient)

X Ashley Fuentes
(Signature of Patient)

X 09/17/25
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

09/17/25
(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.

X Signed: Ashley Jute Date: 09/17/25

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: Ashley Jute Date: 09/17/25

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: Ashley Jute Date: 09/17/25



MOBILE PORTABLE X-RAY ORDER FORM

DATE 9/11/12

YOUR INFORMATION:

NAME Kuentz, Ashley D.O.B. 3/7/03 SS# _____ MALE FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____

FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE NAME _____ INSURANCE ID # _____

SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES Complete 3 or more views <input type="checkbox"/> 70150</p> <p>FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views <input type="checkbox"/> 70360</p> <p>ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p>SI JOINTS Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views <input type="checkbox"/> 71120</p> <p>THORACIC 3 views <input type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY</p> <p>EXTREMITY Lower. 2 views <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS min. 2 views <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME Scarborough, Dr. NPI# _____ FAX RESULTS TO _____

INDICATE REASON FOR STUDY H/O Pathology + FX SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN _____ TECHNIQUE _____ # OF VIEWS _____

X-RAY SENT TO RADIOLOGIST _____ DATE X-RAY SENT / / PATIENT ID # _____ # OF CD _____

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

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radlology Interpretation

PATIENT NAME: FUENTES ASHLEY
DATE OF BIRTH: 03/07/2003
ID/MRN: 20250917143258239
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 09/17/2025
HISTORY: R/O PATHOLOGY M25.511-PAIN IN RIGHT SHOULDER, M25.561-PAIN IN RIGHT KNEE

RIGHT SHOULDER X-Ray Complete 2 or more views:

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

IMPRESSION:

Negative right shoulder.

RIGHT KNEE X-Ray - 3 view:

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

IMPRESSION:

No significant abnormalities noted

Electronically Signed By: Steven Brownstein MD 09/17/2025 20:42:23 EDT

Tech: Dynamic Mobile Xray Services LLC

PATIENT DEMOGRAPHIC FORM 09/17/2025

GUTIERREZ, AMARCIA

DOB: 01/19/1967

Cell Phone: 347-664-0347

Sex: Female

Home phone:

DOA: 08/28/2025

Social Security Number:

Case type: No Fault

Address: 212 W KINGSBRIDGE APT 1C, Bronx, NY, 10463

Primary Insurance: STATE FARM INS

Address: PO BOX 106170, Atlanta, GA, 30348

Claim Number: 3290D584D

Policy Number: 32-9E15-N66

Policy Holder: GUTIERREZ, AMARCIA

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: ALEXANDER BESPECHNY

Address: 2360 WESTCHESTER AVENUE, Bronx, NY, 10462

Phone number: 718-792-4800

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office: 2354 Chiropractic PC

DYNAMIC MOBILE XRAY SERVICES LLC

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

Radiology Interpretation

PATIENT NAME: GUITERREZ AMARCIA
DATE OF BIRTH: 01/19/1967
ID/MRN: 20250917110741945
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 09/17/2025
HISTORY: M25.512-PAIN IN LEFT SHOULDER, M25.562-PAIN IN LEFT KNEE

LEFT SHOULDER X-Ray Complete 2 or more views:

COMPARISON:
None
BONES:
No acute fracture or concerning focal osseous lesion.
JOINTS:
No dislocation. The joint spaces are normal.
SOFT TISSUES:
The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

LEFT KNEE X-Ray - 3 view:

COMPARISON:
None
BONES:
No acute fracture or concerning focal osseous lesion.
JOINTS:
No dislocation. The joint spaces are normal.
SOFT TISSUES:
The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

Electronically Signed By: Dr. Asif Anwar M.D. 09/17/2025 12:19:27 EDT

Tech: Dynamic Mobile Xray Services LLC

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

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

Claim Number: _____

X I, Amarcia Putierrez, ("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.

X Amarcia Putierrez
(Print name of Patient)

X Amarcia Putierrez
(Signature of Patient)

(Address of Patient)

X 9/17/25
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

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

9/17/25
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301

Tel: (570) 243-1888

X-Ray Consent Form

Parent Consent To X-Ray:

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

X Signed: Amarcia Gutierrez Date: 9/17/25

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: Amarcia Gutierrez Date: 9/17/25

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: Amarcia Gutierrez Date: 9/17/25



MOBILE PORTABLE X-RAY ORDER FORM

DATE 9/17/25

YOUR INFORMATION:

NAME Butierrez, Amarcia D.O.B. 11/19/67 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES Complete 3 or more views <input type="checkbox"/> 70150</p> <p>FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND Complete 3 views - R <input type="checkbox"/> <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views <input type="checkbox"/> 70360</p> <p>ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input type="checkbox"/> L <input checked="" type="checkbox"/> 73030</p> <p>SI JOINTS Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views <input type="checkbox"/> 71120</p> <p>THORACIC 3 views <input type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY</p> <p>EXTREMITY Lower. 2 views <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS min. 2 views <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME Scarborough, D.C. NPI# _____ FAX RESULTS TO () _____
 INDICATE REASON FOR STUDY Arthritis / Rx SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN _____ TECHNIQUE _____ # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST _____ DATE X-RAY SENT ____ / ____ / ____ PATIENT ID # _____ # OF CD _____

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