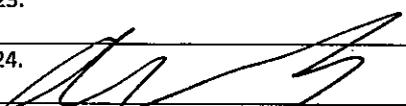
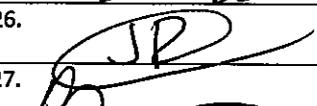
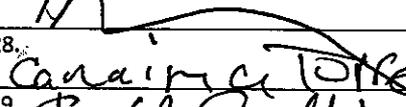
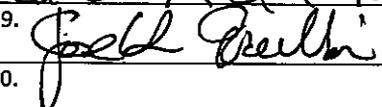


1955 Southern Blvd

### DAILY SIGN IN

DATE: 10/15/2025

PLEASE PRINT NAME

PATIENT NAME	PATIENT NAME
1. Christina Negron ✓	21.
2. Sapphire Pasada ✓	22.
3. Leovina Garcia ✓	23.
4. Areide Figueroa ✓	24. 
5. Thomas Bullock ✓	25. Thomas Bullock
6. Juan Ramirez ✓	26. 
7. Damaris ✓	27. 
8. Carolina Torres ✓	28. Carolina Torres
9. GONZALEZ Miguel ✓	29. 
10. Jose Gault ✓	30.
11. Feliciano Amalio	31.
12. Gardo Ramirez R	32.
13. Desmond Singleton	33.
14. Mohammed Ali	34.
15. Isabelle M. Diaz	35. I. Diaz
16. Joseph Galt	36.
17. Bouhana Boune	37.
18.	38.
19.	39.
20.	40.

**(01180)-GALLO JOSEPH**

Date of Birth - 2/28/1990 Sex - Male Marital Status - Single

Address: 8011 GLENDALE, New York, NY, 11385  
Phone #: (631) 672-2097

Social Security# - 056-78-9268

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 10/8/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : FARMERS

Address:

Phone: Fax:

Claim# -

Policy Effective Date -

Policy# - 0594133610

Policy holder - GALLO, JOSEPH

WCB# -

Carrier case # -

To Attorney - SANDERS LAW Firm Name - SANDERS LAW  
Attorney Address - 1019 AVE P SUITE 201 BROOKLYN, NY 11223  
Attorney Phone - 718-874-8869 Fax - 718-928-6886  
Contact Person -

Other Insurance -

Medicare -

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

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

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

X I, Joseph Cocco ("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 Joseph Cocco  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

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

X 10/15/2025  
(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)

10/15/2025  
(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: \_\_\_\_\_ Date: 10/15/2025

**Consent To X-Ray:**

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Females: Regarding Possibility of Pregnancy**

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_



**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 10/15/25

**YOUR INFORMATION**

NAME Gallo Joseph D.O.B. 2/28/25 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/ &amp; 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 &amp; ext. 7 view <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><b>KNEE</b> ..... Limited 1 or 2 views R <input checked="" 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 &amp; 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><b>SHOULDER</b> ..... Complete, 2 views - R <input checked="" 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><b>INFANT X-RAY</b></p> <p>EXTREMITY Lower. 2 views ..... <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views ..... <input type="checkbox"/> 73092</p> <p>PELVIS &amp; 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 Muhammad Zahara NPI# 144726824 FAX RESULTS TO (\_\_\_\_) \_\_\_\_\_  
 INDICATE REASON FOR STUDY 12/0 fx/pain 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 SERVICE LLC**

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

**Radiology Interpretation**

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**PATIENT NAME:** GALLO JOSEPH  
**DATE OF BIRTH:** 02/28/1990  
**ID/MRN:** 20251015142838865  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER

---

**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.**

---

**RIGHT KNEE X-Ray - 1-2 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.**

**Evaluation is limited by poor image quality.**

---

**Electronically Signed By: Dr. Asif Anwar M.D. 10/16/2025 12:22:56 EDT**

**Tech: Dynamic Mobile Xray Services LLC**

**(01055)-NEGRON CHRISTINA**

Date of Birth - 02/28/1988 Sex - Female Marital Status - Single

Address: 1180 E 178TH ST #3,The Bronx,NY,10460  
Phone #: (929) 582-1226

Social Security# -

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 07/24/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 88514921700000013

Claim Address - GEICO NY PIP

PO Box 9507

Fredericksburg, VA 22403-9526

NF-2 - Yes Sending Date - 08/22/2025

Policy Effective Date -

Policy# - 6203259079

Policy holder - ALEXIS DE LA CRUZ

WCB# -

Carrier case # -

Attorney - MARK KANDKHOROV, ESQ Firm Name - MARK KANDKHOROV, ESQ

Attorney Address -

Attorney Phone - 212-888-8899 Fax - Contact Person -

Other Insurance -

Medicare -

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

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

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

X Christina Negron ("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 Christina Negron  
(Print name of Patient)

X C. Negron  
(Signature of Patient)

X 10/15/2025  
(Date of signature)

1180 E 175<sup>th</sup> St Apt 3 10460  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

10/15/2028  
(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: L. Negeon. Date: 10/15/2025

**Consent To X-Ray:**

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**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: L. Negeon. Date: 10/15/25

**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

---

**PATIENT NAME:** NEGRON CHRISTINA  
**DATE OF BIRTH:** 02/28/1988  
**ID/MRN:** 20251015114639052  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.522-PAIN IN LEFT ELBOW, M25.511-PAIN IN RIGHT SHOULDER

---

**RIGHT SHOULDER X-Ray Complete 2 or more views:**

**COMPARISON:** None.

**FINDINGS:**

There is no radiographic evidence of acute fracture.  
There are no gross lytic or blastic lesions in the bones.  
There is no abnormal radiopaque foreign body.  
There is no dislocation.  
The joint spaces are unremarkable.

**IMPRESSION:**

**There is no radiographic evidence of acute disease.**

---

**LEFT ELBOW X-Ray - 2 view:**

**COMPARISON:** None.

**FINDINGS:**

There is no radiographic evidence of acute fracture.  
There are no gross lytic or blastic lesions in the bones.  
There is no abnormal radiopaque foreign body.  
There is no dislocation.  
The joint spaces are unremarkable.

**IMPRESSION:**

**There is no radiographic evidence of acute disease.**

---

**Electronically Signed By:** William Betz M.D. 10/15/2025 13:03:32 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**DYNAMIC**  
MOBILE XRAY SERVICES LLC

Phone: (570)243-1888  
Fax: 570-209-5771

Email: dynamcmobilexrays@gmail.com  
website: dynamcmobilexray.com

**MOBILE PORTABLE X-RAY ORDER FORM**

DATE 10/15/25

**YOUR INFORMATION:**

NAME Negron christina D.O.B. 2/28/88 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><b>ABDOMEN</b> ..... 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><b>AC JOINTS W/ &amp; W/O WEIGHTS</b>          2 views ..... <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600          Complete 3 views ..... <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> ..... 1 view ..... <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> .. Complete ..... <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72040          Complete w/min. 4 views ..... <input type="checkbox"/> 72050          Complete w/flex &amp; ext. 7 views ..... <input type="checkbox"/> 72052</p> <p><b>CHEST</b> ..... 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><b>CLAVICLE</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p><b>ELBOW</b> ..... Complete 2 views - R <input type="checkbox"/> L <input checked="" type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b>.. Complete 3 or more views..... <input type="checkbox"/> 70150</p> <p><b>FEMUR</b>..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> ..... 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><b>FOREARM</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b>..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b>..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> ..... 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><b>HUMERUS</b>..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> ..... 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><b>LUMBAR</b> ..... 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><b>MANDIBLE</b> ..... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100          Complete 4 views..... <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> ..... Complete min. 3 views ..... <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> .. Comp. min. 3 views ..... <input type="checkbox"/> 70160</p> <p><b>NECK</b>..... Soft tissue 2 views..... <input type="checkbox"/> 70360</p> <p><b>ORBITS</b>..... Complete 4 views..... <input type="checkbox"/> 70200          MRI screening..... <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170</p> <p><b>RIBS</b> ..... 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><b>SACRUM &amp; COCCYX</b>. Min. 3 views..... <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> ..... 2 views - ..... R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b>..... 3 views..... <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b>..... Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p><b>SI JOINTS</b>..... Complete, 2 views..... <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> ..... Limited 2 or less..... <input type="checkbox"/> 70210          Complete 3+ views ..... <input type="checkbox"/> 70220</p> <p><b>SKULL</b> ..... Limited 3 views or less..... <input type="checkbox"/> 70250          Complete 4 views..... <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> ..... Complete 2 views..... <input type="checkbox"/> 71120</p> <p><b>THORACIC</b>..... 3 views..... <input type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b>. 2 views..... <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b>          Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b>..... Bilateral open/closed ..... <input type="checkbox"/> 70330</p> <p><b>TOE #</b>..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b>  <b>EXTREMITY Lower</b>. 2 views..... <input type="checkbox"/> 73592  <b>EXTREMITY Upper</b>. 2 views..... <input type="checkbox"/> 73092  <b>PELVIS &amp; HIPS</b> .. min. 2 views..... <input type="checkbox"/> 73540  <b>WRIST</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100  <b>OTHER</b> _____</p>
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**REQUESTING PHYSICIAN:**

NAME Muhammad R Zakaria NPI# 1447269824 FAX RES 610-329-1100  
 INDICATE REASON FOR STUDY NO PAIN 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.

**(01161)-POSADAS SAPPHIRE D**

Date of Birth - 5/17/1999 Sex - Female Marital Status - Single

Address: 79 ALEXANDER ST, YONKERS, NY, 10701

Phone #: (347) 570-2005

Social Security# - XXX-XX-3574

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 9/24/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : Integon National Insurance Co.

Address: P.O.Box 22086

Burlington, NJ, 27215

Phone: 518--431-6410 Fax:

Claim# -

Claim Address - P.O. BOX 1623

WINSTON-SALEM, NC 27102

Policy Effective Date -

Policy# - INT60220749801

Policy holder - MICHELLE RIBGOLONGO

WCB# -

Carrier case # -

Attorney - Bruce Newborough Firm Name - Bruce Newborough, PC

Attorney Address - 2104 Flatbush Avenue Brooklyn, NY 11234

Attorney Phone - 718-701-8826 Fax - 718-332-7334

Contact Person -

Other Insurance -

Medicare -

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

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

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

X I, Sapphire P. ("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 Sapphire Poseadas  
(Print name of Patient)

X SP  
(Signature of Patient)

X 10/15/2025  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

10/15/2028  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)



**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

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**PATIENT NAME:** POSADO SAPPHIRE  
**DATE OF BIRTH:** 05/17/1999  
**ID/MRN:** 20251015115442954  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER

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**RIGHT SHOULDER X-Ray Complete 2 or more views:**

Comparison: None

**FINDINGS:**

Multiple views of the right 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 right shoulder.**

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**Electronically Signed By:** Dr. Lan Vu M.D. 10/15/2025 13:00:10 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/25

**YOUR INFORMATION:**

NAME Posada Sapphire D.O.B. 5/17/99 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/ &amp; 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 &amp; 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 &amp; 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><b>SHOULDER</b> ..... 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><b>INFANT X-RAY</b></p> <p>EXTREMITY Lower, 2 views ..... <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper, 2 views ..... <input type="checkbox"/> 73092</p> <p>PELVIS &amp; 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 Muhammad R. Zaheng NPI# 1447269824 FAX RESULTS TO  Dr. Zaheng  
 INDICATE REASON FOR STUDY R/O pain SIGNATURE \_\_\_\_\_

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_  
 X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT 1/1 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.

**(01144)-GARCIA LEOVINCI**

Date of Birth - 3/6/1974 Sex - Male Marital Status - Single

Address: 915 BRUCKNER BLVD, The Bronx, NY, 10459  
Phone #: (347) 791-8512

Social Security# - 582-43-7775

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 9/18/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 8814261170000001

Claim Address - GEICO NY PIP

PO Box 9506

Fredericksburg, VA 22403-9506

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - MARK KANDKHOROC, ESQ Firm Name - MARK KANDKHOROC, ESQ

Attorney Address - 215-15 NORTHERN BOULEVARD 3RDFL BAYSIDE, NY 11361

Attorney Phone - 718-998-6788 Fax - Contact Person -

Other Insurance -

Medicare -

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

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

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

X I. Leovina Garcia, ("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 I. Leovina Garcia  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

X 10/15/2028  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

10/15/2028  
(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: Lauren Hara Date: 10/15/2025

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: Lauren Hara Date: \_\_\_\_\_

Females: Regarding Possibility of Pregnancy

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

X Signed: Lauren Hara Date: \_\_\_\_\_

**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

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**PATIENT NAME:** GARCIA LEOVINCI  
**DATE OF BIRTH:** 03/06/1974  
**ID/MRN:** 20251015121121349  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.512-PAIN IN LEFT SHOULDER

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**LEFT SHOULDER X-Ray Complete 2 or more views:**

Shoulder series

Technique: Internal and external rotation views

Comparison: None.

Findings:

Anatomic alignment is maintained.  
There is no acute fracture or dislocation.  
The soft tissues are unremarkable.  
There are no erosive changes seen.  
The acromioclavicular and gleno-humeral joints are intact.

**IMPRESSION:**

**No acute fracture or dislocation. Normal exam of the shoulder.**

---

**Electronically Signed By:** Dr. Justin Pham M.D. 10/15/2025 13:06:39 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/25

**YOUR INFORMATION:**

NAME Garcia Leonardo D.O.B. 3/16/74 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/ &amp; 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 &amp; 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 &amp; 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><b>SHOULDER</b> ..... 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><b>INFANT X-RAY</b></p> <p>EXTREMITY Lower. 2 views ..... <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views ..... <input type="checkbox"/> 73092</p> <p>PELVIS &amp; 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 Muhammad R. Zakaria NPI# 144726924 FAX RESULT TO    
 INDICATE REASON FOR STUDY R/O pain 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.

**(01052)-FIGUEROA ARCADE JR**

Date of Birth - 7/15/1980 Sex - Male Marital Status - Single

Address: 120 E 123 ST, New York, NY, 10035  
Phone #: (332) 285-7122

Social Security# - 079-66-0802

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 7/22/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 8835351150000006

Claim Address - GEICO NY PIP

PO Box 9507

Fredericksburg, VA 22403-9526

NF-2 - Yes Sending Date - 08/21/2025

Policy Effective Date -

Policy# - 6186259138

Policy holder - JOHNATHAN WALLACE

WCB# -

Carrier case # -

Attorney - SULAYMANOV LAW GROUP, PC Firm Name - SULAYMANOV LAW GROUP, PC

Attorney Address -

Attorney Phone - 347-682-4822 Fax - 917-633-5973

Contact Person -

Other Insurance -

Medicare -

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

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

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

X Arccide Figueroa ("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.

Arccide Figueroa

X Arccide Figueroa  
(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 [Signature]  
(Signature of Patient)

X 10/15/2025  
(Date of signature)

[Signature]  
(Signature of Provider)

10/15/2025  
(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: [Signature] Date: 10/05/2025

**Consent To X-Ray:**

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Females: Regarding Possibility of Pregnancy**

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

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**PATIENT NAME:** FIGUERO ARCIDE  
**DATE OF BIRTH:** 07/15/1980  
**ID/MRN:** 20251015121903683  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER

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**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 normal. Mild narrowing of gleno-humeral joint space and AC joints.

**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. Mild degree of osteoarthritis.
- 

**Electronically Signed By:** Dr. Naiyer Imam M.D. 10/16/2025 2:51:42 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/25

**YOUR INFORMATION**

NAME Figueroa Avcede D.O.B. 7/15/80 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><b>ABDOMEN</b> .... 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><b>AC JOINTS W/ &amp; W/O WEIGHTS</b>          2 views ..... <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600          Complete 3 views ..... <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> ..... 1 view ..... <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> .. Complete ..... <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72040          Complete w/min. 4 views ..... <input type="checkbox"/> 72050          Complete w/flex &amp; ext. 7 views <input type="checkbox"/> 72052</p> <p><b>CHEST</b> ..... 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><b>CLAVICLE</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p><b>ELBOW</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b>.. Complete 3 or more views ..... <input type="checkbox"/> 70150</p> <p><b>FEMUR</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> .. Complete min. 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> ..... 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><b>FOREARM</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> ..... 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><b>HUMERUS</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> ..... 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><b>LUMBAR</b> ..... 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><b>MANDIBLE</b> .... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100          Complete 4 views ..... <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> .... Complete min. 3 views ..... <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> .. Comp. min. 3 views ..... <input type="checkbox"/> 70160</p> <p><b>NECK</b> ..... Soft tissue 2 views ..... <input type="checkbox"/> 70360</p> <p><b>ORBITS</b> ..... Complete 4 views ..... <input type="checkbox"/> 70200          MRI screening ..... <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170</p> <p><b>RIBS</b> ..... 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><b>SACRUM &amp; COCCYX</b>. Min. 3 views ..... <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> ..... 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b> ..... 3 views ..... <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b> ..... Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p><b>SI JOINTS</b> ..... Complete, 2 views ..... <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> ..... Limited 2 or less ..... <input type="checkbox"/> 70210          Complete 3+ views ..... <input type="checkbox"/> 70220</p> <p><b>SKULL</b> ..... Limited 3 views or less ..... <input type="checkbox"/> 70250          Complete 4 views ..... <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> ..... Complete 2 views ..... <input type="checkbox"/> 71120</p> <p><b>THORACIC</b> ..... 3 views ..... <input type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b>. 2 views ..... <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b>          Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b> ..... Bilateral open/closed ..... <input type="checkbox"/> 70330</p> <p><b>TOE #</b> ..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b>  <b>EXTREMITY Lower</b>. 2 views ..... <input type="checkbox"/> 73592  <b>EXTREMITY Upper</b>. 2 views ..... <input type="checkbox"/> 73092  <b>PELVIS &amp; HIPS</b> .. min. 2 views ..... <input type="checkbox"/> 73540  <b>WRIST</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100  <b>OTHER</b> _____</p>
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**REQUESTING PHYSICIAN**

NAME Muhammad R. Zohary NPI# 1447269924 FAX RESULTS TO  John  
 INDICATE REASON FOR STUDY PO pain SIGNATURE \_\_\_\_\_

**FOR OFFICE USE ONLY**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_  
 X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT 1 / 1 / \_\_\_\_\_ 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.

**(01164)-BULLOCK THOMAS**

Date of Birth - 7/20/1980 Sex - Male Marital Status - Single

Address: 1780 WASTON AVE,The Bronx,NY,10472

Phone #: (347) 994-6911 -

Social Security# - 093-66-6646

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 9/26/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : American Transit Insurance Co.

Address: 275 7-Ave 2FL

New York,NY,10001

Phone: 800-683-2842 Fax: 2128578248

Claim# - 1176902-04

Claim Address - 5 Broadway

Freeport, New York 11520

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - PINKHASLAW Firm Name - PINKHASLAW

Attorney Address - 185-22 UNION TPKE SUITE 202 FRESH MEADOWS,NY,11366

Attorney Phone - 212-884-0393 Fax - 212-898-1119

Contact Person -

Other Insurance -

Medicare -

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

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

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

X I, Thomas Bullock ("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 Thomas Bullock  
(Print name of Patient)

X Thomas Bullock  
(Signature of Patient)

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

X 10/15/2025  
(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)

10/15/2025  
(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: Sharon Bennett Date: 10/15/2025

**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: Sharon Bennett Date: \_\_\_\_\_

**Females: Regarding Possibility of Pregnancy**

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### DYNAMIC MOBILE XRAY SERVICE LLC

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

#### Radiology Interpretation

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**PATIENT NAME:** BULLOCK THOMAS  
**DATE OF BIRTH:** 07/20/1980  
**ID/MRN:** 20251015122438136  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER, M25.561-PAIN IN RIGHT KNEE

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#### **RIGHT SHOULDER X-Ray Complete 2 or more views:**

**RIGHT SHOULDER:**

Right shoulder two view: There is no evidence of fracture or dislocation. The joint spaces are intact. No osseous or soft tissue pathology.

**IMPRESSION:**

**Negative study.**

---

#### **RIGHT KNEE X-Ray - 1-2 view:**

**RIGHT KNEE:**

Right knee two view: No fracture. Alignment is normal. The joint spaces are intact. No effusion. No osseous or soft tissue pathology.

**IMPRESSION:**

**Negative study.**

---

**Electronically Signed By:** Dr. Joseph Dixon M.D. 10/16/2025 9:55:27 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/20

**YOUR INFORMATION:**

NAME BULLOCK THOMAS D.O.B. 07/20/80 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/ &amp; 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 &amp; 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/fordotic 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"/> 73600</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><b>KNEE</b> ..... Limited 1 or 2 views R <input checked="" 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 &amp; 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><b>SHOULDER</b> ..... Complete, 2 views - R <input checked="" 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><b>INFANT X-RAY</b></p> <p>EXTREMITY Lower. 2 views ..... <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views ..... <input type="checkbox"/> 73092</p> <p>PELVIS &amp; 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 Muhammad R. Zakaria NPI# 1447269824 FAX RESULTS TO 733  
 INDICATE REASON FOR STUDY No fx/pain 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.

**(01113)-RAMIREZ JUAN R**

Date of Birth - 3/26/1992 Sex - Male Marital Status - Single

Address: 1182 W FARMS,The Bronx,NY,10459  
Phone #: (917) 938-9257

Social Security# - 083-80-6634

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 9/8/2025

Time/Place Accident -

Policy Report - Yes

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO General Insurance Co.

Address:

Phone: Fax:

Claim# - 8809131580000001

Claim Address - GEICO NY PIP

PO Box 9507

Fredericksburg, VA 22403-9506

Policy Adjuster - JERMAIN

6 714 7319

Policy Effective Date -

Policy# - 6158392826

Policy holder - JUAN RAMIREZ

WCB# -

Carrier case # -

Attorney - THE SANDERS LAW FIRM Firm Name - THE SANDERS LAW FIRM

Attorney Address - 1938 CONEY ISLAND AVE, BROOKLYN, NY, 11230, STE #201

Attorney Phone - 718-874-8869 Fax - 718-928-6886

Contact Person -

Other Insurance -

Medicare -

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

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

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

X I, Juan Ramirez, ("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 Juan Ramirez  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

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

X 10/15/2025  
(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)

10/15/2025  
(Date of signature)



**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

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**PATIENT NAME:** RAMIREZ JUAN  
**DATE OF BIRTH:** 03/26/1992  
**ID/MRN:** 20251015123900877  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.512-PAIN IN LEFT SHOULDER

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**LEFT SHOULDER X-Ray Complete 2 or more views:**

Technique: Left 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 normal.

**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.**

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**Electronically Signed By:** Dr. Naiyer Imam M.D. 10/16/2025 3:20:50 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/25

**YOUR INFORMATION**

NAME Ramirez Juan D.O.B. 3/26/92 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 <b>SHOULDER</b> ..... Complete, 2 views - R <input 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 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 SKULL ..... Limited 3 views or less ..... <input type="checkbox"/> 70250 Complete 4 views ..... <input type="checkbox"/> 70260
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	STERNUM ..... Complete 2 views ..... <input type="checkbox"/> 71120 THORACIC ..... 3 views ..... <input type="checkbox"/> 72072 THORACOLUMBAR. 2 views ..... <input type="checkbox"/> 72080
BONE AGE ..... 1 view ..... <input type="checkbox"/> 77072 BONE SURVEY .. Complete ..... <input type="checkbox"/> 77075	MANDIBLE ..... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views ..... <input type="checkbox"/> 70110	TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590
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	MASTOIDS ..... Complete min. 3 views ..... <input type="checkbox"/> 70130 NASAL BONES .. Comp. min. 3 views ..... <input type="checkbox"/> 70160 NECK ..... Soft tissue 2 views ..... <input type="checkbox"/> 70360	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
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	<b>INFANT X-RAY</b> EXTREMITY Lower. 2 views ..... <input type="checkbox"/> 73592 EXTREMITY Upper. 2 views ..... <input type="checkbox"/> 73092
CLAVICLE ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000	PELVIS ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170 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	PELVIS & HIPS .. min. 2 views ..... <input type="checkbox"/> 73540 WRIST ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100 OTHER _____
ELBOW ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080		
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 Muhammad Zafar NPI# 1447269824 FAX RESULTS TO \_\_\_\_\_  
 INDICATE REASON FOR STUDY n/o pain/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.

**(01183)-FELICIANO AMALIO**

Date of Birth - 9/6/1977 Sex - Male Marital Status - Single

Address: 2804 MILES AVE, The Bronx, NY, 10465  
Phone #: (929) 412-9660

Social Security# - XXX-XX-2785

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 10/12/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : MVAIC

Address: 110 William Street  
New York, NY, 10038

Phone: 212-791-1280 Fax:

Claim# -

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - Firm Name -

Attorney Address -

Attorney Phone - Fax -

Contact Person -

Other Insurance -

Medicare -

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**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

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**PATIENT NAME:** FELICIANO AMALIO  
**DATE OF BIRTH:** 09/06/1977  
**ID/MRN:** 20251015124516698  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER, M25.562-PAIN IN LEFT KNEE

---

**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 normal.

**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.**

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

Technique: Left knee, 2 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 normal. There is no joint effusion. Mild 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 osteoarthritis.**
- 

**Electronically Signed By:** Dr. Naiyer Imam M.D. 10/16/2025 1:36:36 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/25

**YOUR INFORMATION:**

NAME Richard Amato D.O.B. 09/06/77 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/ &amp; 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 &amp; 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><b>KNEE</b> ..... Limited 1 or 2 views R <input type="checkbox"/> L <input checked="" 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 &amp; 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><b>SHOULDER</b> ..... 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><b>INFANT X-RAY</b></p> <p>EXTREMITY Lower. 2 views ..... <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views ..... <input type="checkbox"/> 73092</p> <p>PELVIS &amp; 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 Muhammad R Zafar NPI# 1447269824 FAX RESULTS TO                        
 INDICATE REASON FOR STUDY R/O Ex/pain 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.

**(01166)-SMITH DAMARIS**

Date of Birth - 7/28/2002 Sex - Male Marital Status - Single

Address: 1780 WATSON AVE, The Bronx, NY, 10472  
Phone #: (917) 352-7263

Social Security# - 035-92-1398

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 9/26/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : American Transit Insurance Co.

Address: 275 7-Ave 2FL

New York, NY, 10001

Phone: 800-683-2842 Fax: 2128578248

Claim# - 1176902-06

Claim Address - 5 Broadway

Freeport, New York 11520

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - PINKHASLAW Firm Name - PINKHASLAW

Attorney Address - 185-22 UNION TPKE SUITE 202 FRESH MEADOWS, NY, 11366

Attorney Phone - 212-884-0393 Fax - 212-898-1119

Contact Person -

Other Insurance -

Medicare -

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

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

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

X I, Damaris Smith, ("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 Damaris Smith  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

X 10/15/2025  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

10/15/2028  
(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: Damaris Smith Date: 10/15/2025

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

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

**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

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**PATIENT NAME:** SMITH DAMARIS  
**DATE OF BIRTH:** 07/28/2002  
**ID/MRN:** 20251015130131050  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.512-PAIN IN LEFT SHOULDER, M25.561-PAIN IN RIGHT KNEE, M25.562-PAIN IN LEFT KNEE

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**LEFT SHOULDER X-Ray Complete 2 or more views:**

Technique: Left 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 normal.

**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.**

---

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

Technique: Left knee, 2 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 normal. There is no joint effusion.

**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.**

---

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

Technique: Right knee, 2 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 normal. There is no joint effusion.

**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.**

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**Electronically Signed By:** Dr. Naiyer Imam M.D. 10/16/2025 1:05:35 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/25

**YOUR INFORMATION:**

NAME Smith Jamars D.O.B. 7/28/02 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/ &amp; 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 &amp; 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/iodotic 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><u>KNEE</u> ..... Limited 1 or 2 views R <input checked="" type="checkbox"/> L <input checked="" 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 &amp; 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><u>SHOULDER</u>..... 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><b>INFANT X-RAY</b></p> <p>EXTREMITY Lower, 2 views..... <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper, 2 views..... <input type="checkbox"/> 73092</p> <p>PELVIS &amp; 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 Muhammad R. Zahedi NPI# 1447269824 FAX RESULTS TO \_\_\_\_\_  
 INDICATE REASON FOR STUDY RU fx pain SIGNATURE [Signature]

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_  
 X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT 1/1 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.

**(01165)-TORRES CANAIMA**

Date of Birth - 6/2/1981 Sex - Female Marital Status - Single

Address: 1780 WATSON AVE, The Bronx, NY, 10472

Phone #: (917) 743-8841

Social Security# - 065-66-4826

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 9/26/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : American Transit Insurance Co.

Address: 275 7-Ave 2FL

New York, NY, 10001

Phone: 800-683-2842 Fax: 2128578248

Claim# - 1176902-05

Claim Address - 5 Broadway

Freeport, New York 11520

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - PINKHASLAW INJURY ATTORNEY Firm Name - PINKHASLAW

Attorney Address - 185-22 UNION TPKE SUITE 202 FRESH MEADOWS, NY, 11366

Attorney Phone - 212-884-0393 Fax - 212-898-1119

Contact Person -

Other Insurance -

Medicare -

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

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

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

X Canaima Torres, ("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 Canaima Torres  
(Print name of Patient)

X Canaima Torres  
(Signature of Patient)

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

X 10/15/2025  
(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)

10/15/2025  
(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: Canaïma Torres Date: 10/15/25

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: Canaïma Torres Date: 10/15/25

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: Canaïma Torres Date: 10/15/25

**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

---

**PATIENT NAME:** TORRESS CANAIMA  
**DATE OF BIRTH:** 06/02/1981  
**ID/MRN:** 20251015130857921  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.512-PAIN IN LEFT SHOULDER, M79.672-PAIN IN LEFT FOOT

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**LEFT SHOULDER X-Ray Complete 2 or more views:**

**LEFT SHOULDER:**

Left shoulder two view: There is no evidence of fracture or dislocation. The joint spaces are normal. No osseous or soft tissue pathology.

**IMPRESSION:**

**Negative Study.**

---

**LEFT FOOT X-Ray - 2 view:**

**LEFT FOOT:**

Left foot two views: No acute fracture is seen. Alignment is normal. Joint spaces are intact. No incidental findings.

**IMPRESSION:**

**Negative study.**

---

**Electronically Signed By:** Dr. Joseph Dixon M.D. 10/16/2025 9:56:56 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/25

**YOUR INFORMATION:**

NAME 101ress Canaima D.O.B. 6/2/81 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/ &amp; 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 &amp; 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><b>FOOT</b> ..... Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620          Complete 2 views - R <input type="checkbox"/> L <input checked="" 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 &amp; 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><b>SHOULDER</b> ..... 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><b>INFANT X-RAY</b></p> <p>EXTREMITY Lower. 2 views ..... <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views ..... <input type="checkbox"/> 73092</p> <p>PELVIS &amp; 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 Muhammad Zafar NPI# 1447269824 FAX RESULTS    
 INDICATE REASON FOR STUDY 12/8 fx/ pain SIGNATURE [Signature]

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_  
 X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT 1/1 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.

**(01173)-GONZALEZ MIGUEL**

Date of Birth - 4/15/1994 Sex - Male Marital Status - Single

Address: 1116 MONOR AVE, The Bronx, NY, 10472

Phone #: (929) 944-8702

Social Security# - XXX-22-37

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 10/3/2025

Time/Place Accident -

Date of Visit -

Insurance Company : STATEFARM INS

Address:

Phone: Fax:

Claim# - 3291J398W

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - PINKHASLAW Firm Name - PINKHASLAW

Attorney Address - 185-22 UNION TPKE SUITE 202 FRESH MEADOWS, NY, 11366

Attorney Phone - 212-884-0393 Fax - 212-898-1119

Contact Person -

Other Insurance -

Medicare -

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

**X-Ray Consent Form**

**Parent Consent To X-Ray:**

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

X Signed: \_\_\_\_\_ Date: 10/15/2025

**Consent To X-Ray:**

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Females: Regarding Possibility of Pregnancy**

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

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**PATIENT NAME:** GONZALEZ MIGUEL  
**DATE OF BIRTH:** 04/15/1994  
**ID/MRN:** 20251015131725469  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER, M25.561-PAIN IN RIGHT KNEE, M25.471-EFFUSION, RIGHT ANKLE

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**RIGHT SHOULDER X-Ray Complete 2 or more views:**

**RIGHT SHOULDER:**

Right shoulder two view: There is no evidence of fracture or dislocation. The joint spaces are intact. No osseous or soft tissue pathology.

**IMPRESSION:**

**Negative study.**

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

**RIGHT KNEE:**

Right knee two view: No fracture. Alignment is normal. The joint spaces are intact. No effusion. No osseous or soft tissue pathology.

**IMPRESSION:**

**Negative study.**

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

Right ankle three views: No fracture is seen. Joint spaces are normal. Alignment is normal. No incidental findings.

**IMPRESSION:**

**Negative Study.**

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**Electronically Signed By:** Dr. Joseph Dixon M.D. 10/16/2025 9:39:54 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/25

**YOUR INFORMATION:**

NAME Gonzalez Miguel D.O.B. 04/15/194 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 AC JOINTS W/ & W/O WEIGHTS 2 views..... <input type="checkbox"/> 73050 ANKLE ..... Limited 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views ..... <input type="checkbox"/> 73610 BONEAGE..... 1 view..... <input type="checkbox"/> 77072 BONE SURVEY.. Complete..... <input type="checkbox"/> 77075 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 CHEST ..... Limited 1 view..... <input type="checkbox"/> 71045 Complete 2 views..... <input type="checkbox"/> 71046 Complete w/iodotic 3 views... <input type="checkbox"/> 71047 Complete 4 views..... <input type="checkbox"/> 71048 Special views Decubitus..... <input type="checkbox"/> 71035 CLAVICLE ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000 ELBOW..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080 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	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 checked="" 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 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 MANDIBLE ..... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views..... <input type="checkbox"/> 70110 MASTOIDS ..... Complete min. 3 views ..... <input type="checkbox"/> 70130 NASAL BONES.. Comp. min. 3 views..... <input type="checkbox"/> 70160 NECK ..... Soft tissue 2 views..... <input type="checkbox"/> 70360 ORBITS..... Complete 4 views..... <input type="checkbox"/> 70200 MRI screening..... <input type="checkbox"/> 70030 PELVIS ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170 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	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 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 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 _____
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**REQUESTING PHYSICIAN:**

NAME Muhammad Zafar NPI# 1447269824 FAX RESULTS TO \_\_\_\_\_  
 INDICATE REASON FOR STUDY p/o pain/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.

**(01112)-GRULLON JOSE R**

Date of Birth - 6/14/1966 Sex - Male Marital Status - Single

Address: 911 E 165 ST,The Bronx,NY,10459  
Phone #: (646) 975-8037

Social Security# - 113-80-9192

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 8/31/2025  
Time/Place Accident -  
Date of Visit -  
Condition Related to : Auto Accident

Insurance Company : AMERICAN TRANSIT INSURANCE  
Address:

Phone: Fax:

Claim# - 0806105623  
Claim Address - 5 BROADWAY  
FREEPORT,NY 11520

NF-2 - Yes Sending Date - 09/30/2025  
Policy Adjuster - NANEPTE

0 251 3112  
Policy Effective Date -  
Policy# - 011663  
Policy holder - ALVAREZ YUDHISE  
WCB# -  
Carrier case # -

Attorney - THE SANDERS LAW FIRM Firm Name - THE SANDERS LAW FIRM  
Attorney Address - 1938 CONEY ISLAND AVE, BROOKLYN, NY, 11230, STE #201  
Attorney Phone - 718-874-8869 Fax - 718-928-6886  
Contact Person -

Other Insurance -  
Medicare -

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

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

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

X I, Jose Grollon, ("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 Jose Grollon  
(Print name of Patient)

X Jose R Grollon  
(Signature of Patient)  
X 10/15/2025  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

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

[Signature]  
(Signature of Provider)  
10/15/2025  
(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:  Date: 10/15/2025

**Consent To X-Ray:**

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Females: Regarding Possibility of Pregnancy**

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### DYNAMIC MOBILE XRAY SERVICE LLC

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

#### Radiology Interpretation

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**PATIENT NAME:** GRULLON JOSE  
**DATE OF BIRTH:** 06/14/1966  
**ID/MRN:** 20251015132807741  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER, M25.512-PAIN IN LEFT SHOULDER, M25.561-PAIN IN RIGHT KNEE

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**LEFT SHOULDER X-Ray Complete 2 or more views:**

**LEFT SHOULDER:**  
Left shoulder two view: There is no evidence of fracture or dislocation. The joint spaces are normal. No osseous or soft tissue pathology.

**IMPRESSION:**

**Negative Study.**

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**RIGHT SHOULDER X-Ray Complete 2 or more views:**

**RIGHT SHOULDER:**  
Right shoulder two view: There is no evidence of fracture or dislocation. The joint spaces are intact. No osseous or soft tissue pathology.

**IMPRESSION:**

**Negative study.**

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

**RIGHT KNEE:**  
Right knee two view: No fracture. Alignment is normal. The joint spaces are intact. No effusion. No osseous or soft tissue pathology.

**IMPRESSION:**

**Negative study.**

---

**Electronically Signed By:** Dr. Joseph Dixon M.D. 10/16/2025 9:44:44 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/25

**YOUR INFORMATION:**

NAME Gruillon Jose D.O.B. 6/14/66 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/ &amp; 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 &amp; 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/fordotic 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><b>KNEE</b> ..... Limited 1 or 2 views R <input checked="" 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 &amp; 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><b>SHOULDER</b> ..... Complete, 2 views - R <input checked="" 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><b>INFANT X-RAY</b></p> <p>EXTREMITY Lower. 2 views ..... <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views ..... <input type="checkbox"/> 73092</p> <p>PELVIS &amp; 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 Muhammad Zafarig NPI# 1447269824 FAX RESURTS TO \_\_\_\_\_  
 INDICATE REASON FOR STUDY R/O fx/pain 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.

**(01125)-GARIDO RAMIREZ DIONISIO**

Date of Birth - 3/29/2002 Sex - Male Marital Status - Single

Address: 460 EAST 187TH ST 2,The Bronx,NY,10458  
Phone #: (347) 682-6757

Social Security# - 282-17-7668

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 9/15/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : Progressive

Address:

Phone: Fax:

Claim# - 25806957636

Policy Effective Date -

Policy# - 993875923

Policy holder - TINEO JIMENEZ K

WCB# -

Carrier case # -

Attorney - MARK KANDKHOROV,ESQ Firm Name - KANDKHOROV& ASSOCIATES

Attorney Address - 215-15 NORTHERN BOULEVARD,3RD FL BAYSIDE,NY 11361

Attorney Phone - 212-888-8899 Fax - Contact Person -

Other Insurance -

Medicare -

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

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

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

X I, Dionisio, ("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 Dionisio Garrido Ramirez  
(Print name of Patient)

X Dionisio Garrido Ramirez  
(Signature of Patient)

\_\_\_\_\_

X 10/15/2025  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

10/15/2025  
(Date of signature)

EAST STROUDSBURG PA 18301  
(Address of Provider)

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

**X-Ray Consent Form**

**Parent Consent To X-Ray:**

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

X Signed: Pamela Garrido Ramirez Date: 10/15/2025

**Consent To X-Ray:**

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Females: Regarding Possibility of Pregnancy**

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

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**PATIENT NAME:** GARIDO RAMIREZ  
**DATE OF BIRTH:** 03/29/2002  
**ID/MRN:** 20251015133926137  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.512-PAIN IN LEFT SHOULDER

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**LEFT SHOULDER X-Ray Complete 2 or more views:**

**LEFT SHOULDER:**

Left shoulder two view: There is no evidence of fracture or dislocation. The joint spaces are normal. No osseous or soft tissue pathology.

**IMPRESSION:**

**Negative Study.**

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**Electronically Signed By:** Dr. Joseph Dixon M.D. 10/16/2025 9:32:25 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**DYNAMIC**  
MOBILE XRAY SERVICES LLC

Phone: (570)243-1888  
Fax: 570-209-5771

Email: dynamicmobilexrays@gmail.com  
website: dynam[ic]mobilexray.com

**MOBILE PORTABLE X-RAY ORDER FORM**

DATE 10/15/25

**YOUR INFORMATION:**

NAME David Ramirez D.O.B. 05/29/02 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/ &amp; 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 &amp; 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/sardotc 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 &amp; 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><b>SHOULDER</b> ..... 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><b>INFANT X-RAY</b></p> <p>EXTREMITY Lower. 2 views ..... <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views ..... <input type="checkbox"/> 73092</p> <p>PELVIS &amp; 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 Muhammad Zakaria NPI# 1447269824 FAX RESULTS TO ( ) \_\_\_\_\_  
 INDICATE REASON FOR STUDY 12/0 fx/pain 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.

**(01172)-SINGLETON DEZMOUND**

Date of Birth - 12/4/2002 Sex - Male Marital Status - Single

Address: 2514 BARKER AVE, The Bronx, NY, 10467

Phone #: (929) 523-5849

Social Security# - 091-92-0570

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 10/3/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : American Transit Insurance Co.

Address: 275 7-Ave 2FL

New York, NY, 10001

Phone: 800-683-2842 Fax: 2128578248

Claim# -

Claim Address - 1 METRO TECH CENTER  
BROOKLYN NEW YORK 11201

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - OSTROVSI LAW GROUP Firm Name - OSTROVSKI LAW GROUP

Attorney Address - 2106 FLATBUSH AVENUE BROOKLYN NY 11234

Attorney Phone - 718-719-1195 Fax - 718-691-4600

Contact Person -

Other Insurance -

Medicare -

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

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

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

X I, Dermond Singleton, ("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 Dermond Singleton  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

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

X 10/15/2025  
(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)

10/15/2025  
(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: [Signature] Date: 10/15/2025

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: 10/15/25

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: [Signature] Date: 10/15/25

**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

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**PATIENT NAME:** SINGLETON DEZMOUND  
**DATE OF BIRTH:** 12/04/2002  
**ID/MRN:** 20251015134612619  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER

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**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 normal.

**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.**

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**Electronically Signed By:** Dr. Naiyer Imam M.D. 10/16/2025 1:09:52 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/25

**YOUR INFORMATION:**

NAME Singleton delmound D.O.B. 12/04/02 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><b>ABDOMEN</b> ..... 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><b>AC JOINTS W/ &amp; W/O WEIGHTS</b>          2 views ..... <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600          Complete 3 views ..... <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> ..... 1 view ..... <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> .. Complete ..... <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72040          Complete w/min. 4 views ..... <input type="checkbox"/> 72050          Complete w/flex &amp; ext. 7 views <input type="checkbox"/> 72052</p> <p><b>CHEST</b> ..... Limited 1 view ..... <input type="checkbox"/> 71045          Complete 2 views ..... <input type="checkbox"/> 71046          Complete w/ordotic 3 views <input type="checkbox"/> 71047          Complete 4 views ..... <input type="checkbox"/> 71048          Special views Decubitus ..... <input type="checkbox"/> 71035</p> <p><b>CLAVICLE</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p><b>ELBOW</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b> .. Complete 3 or more views ..... <input type="checkbox"/> 70150</p> <p><b>FEMUR</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> ..... 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><b>FOREARM</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> ..... 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><b>HUMERUS</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> ..... 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><b>LUMBAR</b> ..... 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><b>MANDIBLE</b> ..... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100          Complete 4 views ..... <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> ..... Complete min. 3 views ..... <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> .. Comp. min. 3 views ..... <input type="checkbox"/> 70160</p> <p><b>NECK</b> ..... Soft tissue 2 views ..... <input type="checkbox"/> 70360</p> <p><b>ORBITS</b> ..... Complete 4 views ..... <input type="checkbox"/> 70200          MRI screening ..... <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170</p> <p><b>RIBS</b> ..... 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><b>SACRUM &amp; COCCYX</b>. Min. 3 views ..... <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> ..... 2 views - ..... R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b> ..... 3 views ..... <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b> ..... Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p><b>SI JOINTS</b> ..... Complete, 2 views ..... <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> ..... Limited 2 or less ..... <input type="checkbox"/> 70210          Complete 3+ views ..... <input type="checkbox"/> 70220</p> <p><b>SKULL</b> ..... Limited 3 views or less ..... <input type="checkbox"/> 70250          Complete 4 views ..... <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> ..... Complete 2 views ..... <input type="checkbox"/> 71120</p> <p><b>THORACIC</b> ..... 3 views ..... <input type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b> .. 2 views ..... <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b>          Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b> ..... Bilateral open/closed ..... <input type="checkbox"/> 70330</p> <p><b>TOE #</b> ..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b></p> <p><b>EXTREMITY Lower</b> .. 2 views ..... <input type="checkbox"/> 73592</p> <p><b>EXTREMITY Upper</b> .. 2 views ..... <input type="checkbox"/> 73092</p> <p><b>PELVIS &amp; HIPS</b> .. min. 2 views ..... <input type="checkbox"/> 73540</p> <p><b>WRIST</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p><b>OTHER</b> _____</p>
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**REQUESTING PHYSICIAN:**

NAME Muhammad Zafarig NPI# 1447269824 FAX RESULTS TO [Signature]  
 INDICATE REASON FOR STUDY R/O Fr/pain SIGNATURE [Signature]

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_  
 X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT 1/1 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.

**(01117)-ALI MOHAMMED**

Date of Birth - 3/5/1987 Sex - Male Marital Status - Single

Address: 2443 MACLAY AVE, The Bronx, NY, 10461  
Phone #: (347) 479-7499

Social Security# - 370-31-8189

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 9/7/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : American Transit Insurance Co.

Address: 275 7-Ave 2FL

New York, NY, 10001

Phone: 800-683-2842 Fax: 2128578248

Claim# - 1175218-1

Claim Address - 5 Broadway

Freeport, New York 11520

NF-2 - Yes Sending Date - 10/14/2025

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

To Attorney - SALAH SHAWA Firm Name - SHAWA LAW P.C.

Attorney Address - 100 GLEN ST. STE N 2414, GLEN COVE,

Attorney Phone - 631 805 3404 Fax - Contact Person -

Other Insurance -

Medicare -

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

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

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

X I, Mohammed Ali, ("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 Mohammed Ali  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

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

X 10/15/2025  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

10/15/2028  
(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: 10/15/2025

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: 10/15/25

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: [Signature] Date: 10/15/25

**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

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**PATIENT NAME:** ALI MOHAMMED

**DATE OF BIRTH:** 03/05/1987

**ID/MRN:** 20251015135816757

**CLINICIAN:** ZAKARIA, MOHAMMED

**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC

**DATE OF EXAM:** 10/15/2025

**HISTORY:** M25.512-PAIN IN LEFT SHOULDER, M25.522-PAIN IN LEFT ELBOW, M25.562-PAIN IN LEFT KNEE, M25.472-EFFUSION, LEFT ANKLE, M25.532-PAIN IN LEFT WRIST

---

**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.**

---

**LEFT ELBOW X-Ray - 2 view:**

Comparison: None

**FINDINGS:**

Multiple views of the left elbow show normal alignment without acute fractures or dislocations.

The joint spaces are normal.

There is no joint effusion.

There is no elbow region soft tissue swelling.

There are no radiopaque foreign bodies.

If there is further concern, recommend follow-up radiographs or MRI for complete assessment.

**IMPRESSION:**

**No acute fracture or dislocation of the left elbow.**

---

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

Comparison: None

**FINDINGS:**

Multiple views of the left wrist show no acute fractures or dislocations.

There is normal alignment of the carpal bones.

The radiocarpal joint is unremarkable.

The distal radial ulnar joint is unremarkable.

There is no soft tissue swelling.

No joint effusion is seen.

There are no radio-opaque foreign bodies.

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

**IMPRESSION:**

**No acute fracture or dislocation of the left wrist.**

---

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

Comparison: None

**FINDINGS:**

Multiple views of the left knee show normal alignment without acute fractures or dislocations.

The medial and lateral tibiofemoral compartments and patellofemoral compartment are unremarkable.

There are no joint bodies.

There is no knee region soft tissue swelling.

There is no joint effusion.

There are no radiopaque foreign bodies.

If there is further concern, recommend follow-up radiographs or MRI for complete assessment.

**IMPRESSION:**

**No acute fracture or dislocation of the left knee.**

---

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

Comparison: None

**FINDINGS:**

Multiple views of the left ankle show normal alignment without acute fractures or dislocations.

The tibiotalar joint and talar dome are unremarkable.

The subtalar joint is unremarkable.

There is no ankle joint effusion.

The ankle mortise is normal.

The distal tibia-fibular alignment is unremarkable.

There is no soft tissue swelling.

No radiopaque foreign bodies are seen.

If there is further concern, recommend follow-up radiographs or MRI for complete assessment.

**IMPRESSION:**

**No acute fracture or dislocation of the left ankle.**

---

**Electronically Signed By:** Dr. Lan Vu M.D. 10/16/2025 12:16:59 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/25

**YOUR INFORMATION:**

NAME Ali Mohammed D.O.B. 3/5/87 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 ..... 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/ &amp; W/O WEIGHTS          2 views ..... <input type="checkbox"/> 73050</p> <p>ANKLE ..... Limited 2 views - R <input type="checkbox"/> L <input checked="" 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 &amp; 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 2 views - R <input type="checkbox"/> L <input checked="" 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 checked="" 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 &amp; 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 checked="" type="checkbox"/> 73110</p> <p>INFANT X-RAY          EXTREMITY Lower. 2 views ..... <input type="checkbox"/> 73592          EXTREMITY Upper. 2 views ..... <input type="checkbox"/> 73092          PELVIS &amp; HIPS .. min. 2 views ..... <input type="checkbox"/> 73540          WRIST ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100          OTHER _____</p>
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**REQUESTING PHYSICIAN:**

NAME Muhammad Zakaria NPI# 1447269924 FAX RESULTS TO \_\_\_\_\_  
 INDICATE REASON FOR STUDY no fx/pain 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.

**(01074)-DIAZ ISABELLE M**

Date of Birth - 2/13/1974 Sex - Male Marital Status - Single

Address: 2115 HONEYWELL APT 4Q, The Bronx, NY, 10460  
Phone #: (718) 973-0801

Social Security# -

Employer or Company Name:

Address:  
Emergency Name:  
Work Phone #:

Date of Accident - 8/7/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : GEICO INSURANCE COMPANY

Address:

Phone: Fax:

Claim# - 8730826340000003

Claim Address - 100 WILLIAM STREET 14TH, FLOOR  
NEWYORK, NY 10038

NF-2 - Yes Sending Date - 09/03/2025

Policy Adjuster - MITCHELLE

6 7147262

Policy Effective Date -

Policy# -

Policy holder -

WCB# -

Carrier case # -

Attorney - MARK KANDKHOROC, ESQ Firm Name - MARK KANDKHOROC, ESQ

Attorney Address -

Attorney Phone - 718-998-6788 Fax - Contact Person -

Other Insurance -

Medicare -

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

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

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

X I, Isabelle M. Diaz, ("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 Isabelle M. Diaz  
(Print name of Patient)

X Isabelle M. Diaz  
(Signature of Patient)

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

X 10/15/2025  
(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)

10/15/2025  
(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: Isabelle M. Diaz Date: 10/15/2025

#### Consent To X-Ray:

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

#### Females: Regarding Possibility of Pregnancy

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

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**PATIENT NAME:** DIAZ ISABELLE  
**DATE OF BIRTH:** 02/14/1974  
**ID/MRN:** 20251015141727576  
**CLINICIAN:** ZAKARIA, MOHAMMED  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 10/15/2025  
**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER, M25.561-PAIN IN RIGHT KNEE

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**RIGHT SHOULDER X-Ray Complete 2 or more views:**

Comparison: None

**FINDINGS:**

Multiple views of the right 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 right shoulder.**

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

Comparison: None

**FINDINGS:**

Multiple views of the right knee show normal alignment without acute fractures or dislocations.

The medial and lateral tibiofemoral compartments and patellofemoral compartment are unremarkable.

There are no joint bodies.

There is no knee region soft tissue swelling.

There is no joint effusion.

There are no radiopaque foreign bodies.

If there is further concern, recommend follow-up radiographs or MRI for complete assessment.

**IMPRESSION:**

**No acute fracture or dislocation of the right knee.**

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**Electronically Signed By:** Dr. Lan Vu M.D. 10/16/2025 12:17:25 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/25

**YOUR INFORMATION:**

NAME  DIAZ ISABELLE  D.O.B.  2-14-79  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/ &amp; 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 &amp; 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><u>KNEE</u> ..... Limited 1 or 2 views R <input checked="" 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 &amp; 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><u>SHOULDER</u> ..... 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><b>INFANT X-RAY</b></p> <p>EXTREMITY Lower. 2 views ..... <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views ..... <input type="checkbox"/> 73092</p> <p>PELVIS &amp; 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  Muhammad Zaharis  NPI#  1447269824  FAX RESULTS TO ( ) \_\_\_\_\_  
 INDICATE REASON FOR STUDY  R/O fx/pain  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.

**(01169)-BUCHANAN BONNIE A**

Date of Birth - 2/11/1968 Sex - Female Marital Status - Single

Address: 235 S LEXINGTON AVE, 7C, WHITE PLAINS, NY, 10606  
Phone #: (914) 806-7119

Social Security# - 051-68-6399

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 9/15/2025

Time/Place Accident -

Date of Visit -

Condition Related to : Auto Accident

Insurance Company : Progressive

Address:

Phone: Fax:

Claim# - 25407699081

Claim Address - P.O.BOX 22016  
ALBANY NEW YORK 12201

Policy Effective Date -

Policy# - 951169132

Policy holder - BONNIE ANN BUCHANAN

WCB# -

Carrier case # -

Attorney - SANDERS LAW Firm Name - SANDERS LAW  
Attorney Address - 1019 AVE P SUITE 201 BROOKLYN, NY 11223  
Attorney Phone - 718-874-8869 Fax - 718-928-6886  
Contact Person -

Other Insurance -

Medicare -

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

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

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

X Bonnie Buchanan ("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 FRAUD 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 Bonnie Buchanan  
(Print name of Patient)

X Bonnie Buchanan  
(Signature of Patient)

X 10/15/05  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

3412 BLUESTONE LANE

\_\_\_\_\_  
(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: Barrie Buchanan Date: 10/15/25

**Consent To X-Ray:**

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

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**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: Barrie Buchanan Date: 10/15/25

**DYNAMIC MOBILE XRAY SERVICE LLC**

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

**Radiology Interpretation**

---

**PATIENT NAME:** BUCHANNAH BONNIE

**DATE OF BIRTH:** 02/11/1968

**ID/MRN:** 20251015144521405

**CLINICIAN:** ZAKARIA, MOHAMMED

**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC

**DATE OF EXAM:** 10/15/2025

**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER, M25.512-PAIN IN LEFT SHOULDER, M25.551-PAIN IN RIGHT HIP, M79.671-PAIN IN RIGHT FOOT

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**LEFT SHOULDER X-Ray Complete 2 or more views:**

**LEFT SHOULDER:**

Left shoulder two view: There is no evidence of fracture or dislocation. The joint spaces are normal. No osseous or soft tissue pathology.

**IMPRESSION:**

**Negative Study.**

---

**RIGHT SHOULDER X-Ray Complete 2 or more views:**

**RIGHT SHOULDER:**

Right shoulder two view: There is no evidence of fracture or dislocation. The joint spaces are intact. No osseous or soft tissue pathology.

**IMPRESSION:**

**Negative study.**

---

**RIGHT Hip X-Ray unilateral 2-3 views :**

**RIGHT HIP:**

Right hip two view: No fracture. The joint space is intact. No significant osseous or soft tissue pathology.

**IMPRESSION:**

**Negative study.**

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

**RIGHT FOOT:**

Right foot three views: No fracture. Alignment is normal. Osseous structures are intact. Calcaneal spurs. Joint spaces are maintained. No incidental findings.

**IMPRESSION:**

**Negative study.**

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**Electronically Signed By:** Dr. Joseph Dixon M.D. 10/16/2025 9:36:56 EDT

**Tech:** Dynamic Mobile Xray Services LLC



**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 10/15/25

**YOUR INFORMATION**

NAME Buchanagh Bonnie D.O.B. 2/11/68 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/ &amp; 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 &amp; 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><b>FOOT</b> ..... Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620          Complete 3 views - R <input checked="" 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><b>HIP</b> ..... Complete 2 views - R <input checked="" 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 &amp; 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><b>SHOULDER</b> ..... Complete, 2 views - R <input checked="" 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><b>INFANT X-RAY</b></p> <p>EXTREMITY Lower. 2 views ..... <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views ..... <input type="checkbox"/> 73092</p> <p>PELVIS &amp; 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 Muhammad Zakariya NPI# 1447269824 FAX RESULTS TO (\_\_\_\_) \_\_\_\_\_  
 INDICATE REASON FOR STUDY R/O fix/pain SIGNATURE [Signature]

**FOR OFFICE USE ONLY**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_  
 X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT 1/1 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.