

DAILY SIGN IN

3060 East
Front

DATE: 10/20/25

PLEASE PRINT NAME

| PATIENT NAME | PATIENT NAME |
|---------------------------|--------------|
| 1. Santana Esmeralda | 21. |
| 2. Figueroa Larissa | 22. |
| 3. Pimentel Carlos | 23. |
| 4. Bautista Solano Manuel | 24. |
| 5. Posano Abren | 25. |
| 6. Mota Sandy | 26. |
| 7. | 27. |
| 8. | 28. |
| 9. | 29. |
| 10. | 30. |
| 11. | 31. |
| 12. | 32. |
| 13. | 33. |
| 14. | 34. |
| 15. | 35. |
| 16. | 36. |
| 17. | 37. |
| 18. | 38. |
| 19. | 39. |
| 20. | 40. |

10/20/2025

(01108)-Rosario Abreu Lot

Date of Birth - 04/01/1997 Sex - Male Marital Status - Married

Address: 65 Jesup Pl #10, The Bronx, NY, 10452

Phone #: (917) 504-1733

Social Security# - 159-73-1102

Employer or Company Name: N/A

Address: N/A

Emergency Name:

Work Phone #:

Date of Accident - 09/10/2025

Time/Place Accident - 2nd Ave between 115th and 116th St

Date of Visit - 09/12/2025

Condition Related to : Auto Accident

Insurance Company : Integon National Insurance

Address:

Phone: Fax:

Claim# - 250777711

Claim Address - P.O. BOX 6580

Saddle Brook NJ 07663

Policy Adjuster - Joy-Ann Joseph 743-999-7312

Policy Effective Date -

Policy# - BR771740-1

Policy holder - Genesis Coronado

WCB# -

Carrier case # -

Attorney - Michelle Klafter, P.C. Firm Name - Law Office of Mitchell Klafter p.c.

Attorney Address - 22-15 street 2nd floor Astoria NY 11105

Attorney Phone - 718.721.5740 Fax - 718.465.1160

Contact Person -

Other Insurance -

Medicare -

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

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

Claim Number: _____

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

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

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

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO 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 Let Brown D
(Print name of Patient)

X Let Brown D
(Signature of Patient)

X 10/20/25
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

10/20/25
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

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

X-Ray Consent Form

Parent Consent To X-Ray:

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

X Signed: *L. St. Howard* Date: 10-20-25

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: *L. St. Howard* Date: 10-20-25

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: *L. St. Howard* Date: 10-20-25

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301
(570) 431-9721 / (570) 209-5771 FAX
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: ROSARIO ABREU**DATE OF BIRTH:** 04/01/1997**ID/MRN:** 20251020144229425**CLINICIAN:** DENNY XAVIER, RODRIGUEZ.MD**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC**DATE OF EXAM:** 10/20/2025**HISTORY:** M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER, M25.472-EFFUSION, LEFT ANKLE

SPINE THORACIC X-RAY 2 view:

Comparison: None

Findings:

The study seems to be DEGRADED by the technical factors (positioning). The upper dorsal spine is excluded on the lateral view.

There is no acute fracture, or dislocation at the visualized spine. The visualized intervertebral disc spaces show no significant narrowing. The paraspinal soft tissue appear unremarkable.

IMPRESSION:**No acute bony abnormality.**

RIGHT SHOULDER X-Ray Complete 2 or more views:

Comparison: None

Findings:

There is no acute fracture, dislocation or subluxation. No osteoblastic or osteolytic lesion noted. No significant arthritic changes. No soft tissue swelling or calcifications are identified.

IMPRESSION:**Negative study.**

LEFT ANKLE X-Ray Complete 3 view:

Comparison: None

Findings:

There is no acute fracture, or dislocation. No osteoblastic or osteolytic lesion noted. Status post subtalar fusion

IMPRESSION:**No acute bony abnormality.**

Electronically Signed By: Dr. AOUS Al-Khaldi M.D. 10/21/2025 23:37:51 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 10/20/22

YOUR INFORMATION:

NAME Kosario Abreu D.O.B. 4/1/97 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

| | | |
|---|--|---|
| ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022 | HAND Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130 HEEL Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650 HIP Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520 | SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220 SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010 SC JOINTS 3 views <input type="checkbox"/> 71130 SHOULDER Complete, 2 views - R <input checked="" type="checkbox"/> L <input 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 checked="" 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 2 views <input checked="" 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 | TMJ Bilateral open/closed <input type="checkbox"/> 70330 |
| CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/tortic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035 | NASAL BONES .. Comp. min. 3 views <input type="checkbox"/> 70160 | TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660 |
| CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000 | NECK Soft tissue 2 views <input type="checkbox"/> 70360 | WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110 |
| ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080 | ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030 | INFANT X-RAY |
| FACIAL BONES.. Complete 3 or more views <input type="checkbox"/> 70150 | PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170 | EXTREMITY Lower. 2 views <input type="checkbox"/> 73592 |
| FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550 | 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 | EXTREMITY Upper. 2 views <input type="checkbox"/> 73092 |
| FINGER(S) # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140 | | PELVIS & HIPS .. min. 2 views <input type="checkbox"/> 73540 |
| 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 | | WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100 |
| FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090 | | OTHER _____ |

REQUESTING PHYSICIAN:

NAME Denny Xavier Rodriguez NPI# 11619033677 FAX RESID# 1619033677
 INDICATE REASON FOR STUDY PTO Ex/pain/trauma SIGNATURE _____ Lic 242152

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.

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.

10/20/2025

(01095)-Santana #2 Esmirna

Date of Birth - 11/24/1981 Sex - Male Marital Status - Married

Address: 1915 Billingsley Ter. #21, The Bronx, NY, 10453
Phone #: (646) 508-7460

Social Security# - 440-63-4124

Employer or Company Name: N/A
Address: N/A
Emergency Name:
Work Phone #:

Date of Accident - 07/15/2025
Time/Place Accident -
Date of Visit - 08/08/2025
Condition Related to : Auto Accident

Insurance Company : Liberty Mutual Insurance
Address:

Phone: Fax:

Claim# - 059926566
NF-2 - No
Policy Adjuster - James McCormack 516-479-0646
Policy Effective Date - 04/18/2025
Policy# - AOS-221-723834-40
Policy holder -
WCB# -
Carrier case # -

Attorney - Nataliya Borushchak, P.C. Firm Name - Nataliya Borushchak, P.C.
Attorney Address - 2663 Coney Island ave 2Floor Brooklyn NY 11223
Attorney Phone - 212.714.2100 Fax - 212.563.1940
Contact Person -

Other Insurance -
Medicare -

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

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

Claim Number: _____

X

I, Esmeralda, ("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

Esmeralda
(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

Esmeralda Bortera
(Signature of Patient)

X

10/20/25
(Date of signature)

[Signature]
(Signature of Provider)

10/20/25
(Date of signature)

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

X-Ray Consent Form

Parent Consent To X-Ray:

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

X Signed: Emilia Suter Date: 10/20/25

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: Emilia Suter Date: 10/20/25

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301
(570) 431-9721 / (570) 209-5771 FAX
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: SANTANA ESMIRNA
DATE OF BIRTH: 11/24/1981
ID/MRN: 20251020174057003
CLINICIAN: DENNY XAVIER, RODRIGUEZ.MD
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 10/20/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.512-PAIN IN LEFT SHOULDER, M25.562-PAIN IN LEFT KNEE

SPINE THORACIC X-RAY 2 view:

COMPARISON:

None

BONES:

No acute fracture or focal osseous lesion.

Bony alignment is anatomic.

DISCS/DEGENERATIVE CHANGES:

The disc spaces are preserved.

SOFT TISSUES:

The adjacent soft tissues appear normal.

IMPRESSION:

No acute osseous process.

LEFT SHOULDER X-Ray Complete 2 or more views:

COMPARISON:

None

BONES:

No acute fracture or concerning focal osseous lesion.

JOINTS:

No dislocation. The joint spaces are normal.

SOFT TISSUES:

The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

LEFT KNEE X-Ray - 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.

Electronically Signed By: Dr. Asif Anwar M.D. 10/21/2025 20:11:53 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 10/20/25

YOUR INFORMATION:

NAME Santana Esmirna D.O.B. 11/24/81 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/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY .. Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/tordotic 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 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 & 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 2 views <input checked="" type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY 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 Ligified 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100 OTHER _____</p> |
|--|---|---|

REQUESTING PHYSICIAN:

NAME Denny Xavier Rodriguez NPI# 1619033677 **Denny Xavier Rodriguez MD**
 INDICATE REASON FOR STUDY Bo Ex/pain/pathology SIGNATURE _____ FAX RESIDENCE NPI# 1619033677
 Lic 242152

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.

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10/20/2025

(01106)-Figueroa Darina

Date of Birth - 09/07/1993 Sex - Female Marital Status - Single

Address: 65 Jesup Pl #1D, Bronx, NY, 10452

Phone #: (917) 687-1033

Social Security# - 000-00-0000

Employer or Company Name: n/a

Address: n/a

Emergency Name: 347-265-0726 Sandy

Work Phone #:

Date of Accident - 09/10/2025

Time/Place Accident - 2nd Ave between 115th and 116th St

Date of Visit - 09/11/2025

Condition Related to : Auto Accident

Insurance Company : Integon National Insurance

Address:

Phone: Fax:

Claim# - 250777711

Claim Address - P.O. BOX 6580

Saddle Brook NJ 07663

Policy Adjuster - Joy-Ann Joseph 743-999-7312

Policy Effective Date -

Policy# - BR771740-1

Policy holder - Genesis Coronado

WCB# -

Carrier case # -

Attorney - Michelle Klaffer, P.C. Firm Name - Law Office of Mitchell Klaffer p.c.

Attorney Address - 22-15 street 2nd floor Astoria NY 11105

Attorney Phone - 718.721.5740 Fax - 718.465.1160

Contact Person -

Other Insurance -

Medicare -

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

X-Ray Consent Form

Parent Consent To X-Ray:

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

X Signed: Darina Date: 10/20/25

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: _____ Date: _____

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301
(570) 431-9721 / (570) 209-5771 FAX
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: FIGUERORA DARINA
DATE OF BIRTH: 09/07/1993
ID/MRN: 20251020155840192
CLINICIAN: DENNY XAVIER, RODRIGUEZ.MD
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 10/20/2025
HISTORY: M25.511-PAIN IN RIGHT SHOULDER, M25.561-PAIN IN RIGHT KNEE

SPINE THORACIC X-RAY 2 view:

Comparison: None

Findings:

The study seems to be DEGRADED by the technical factors (positioning). The upper thoracic spine is excluded on the lateral view

There is no acute fracture, dislocation or subluxation. The intervertebral disc spaces show no significant narrowing. The paraspinal soft tissue appear unremarkable.

IMPRESSION:

Limited study. No acute bony abnormality.

Electronically Signed By: Dr. AOUS Al-Khalidi M.D. 10/21/2025 22:15:26 EDT

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.

Electronically Signed By: Dr. Asif Anwar M.D. 10/21/2025 22:15:26 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 6/20/05

YOUR INFORMATION:

NAME Higuera Darina D.O.B. 9/17/93 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's needed)

| | | |
|---|---|--|
| <p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY .. Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES .. Complete 3 or more views <input type="checkbox"/> 70150</p> <p>FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p> | <p>HAND Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES .. Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views <input type="checkbox"/> 70360</p> <p>ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71113</p> | <p>SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p>SI JOINTS Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views <input type="checkbox"/> 71120</p> <p>THORACIC 2 views <input checked="" type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY</p> <p>EXTREMITY Lower. 2 views <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS .. min. 2 views <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p> |
|---|---|--|

REQUESTING PHYSICIAN

NAME Denny Xavier Rodriguez NPI# 1619033677 FAX RESIDENCE NPI 1619033677
 INDICATE REASON FOR STUDY to fx/pain/pathology SIGNATURE Denny Xavier Rodriguez MD
 Lic 242152

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.

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(01092)-Bautista Solano Manuel

Date of Birth - 11/20/1994 Sex - Male Marital Status - Single

Address: 10 Burbank St #2A, Yonkers, NY, 10710

Phone #: (347) 932-4760

Social Security# - 000-00-000

Employer or Company Name: N/A

Address: N/A

Emergency Name:

Work Phone #:

Date of Accident - 07/16/2025

Time/Place Accident - 2nd Ave & 64th St

Date of Visit - 07/22/2025

Condition Related to : Auto Accident

Insurance Company : State Farm

Address:

''

Phone: Fax:

Claim# - 52-87X4-34K

NF-2 - No

Policy Effective Date -

Policy# -

Policy holder - Neysi Solano

WCB# -

Carrier case # -

Attorney - Firm Name -

Attorney Address -

Attorney Phone - Fax -

Contact Person -

Other Insurance -

Medicare -

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

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

Claim Number: _____

X

I, MANUEL CAUTIAA SOLANO, ("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 MANUEL CAUTIAA SOLANO
(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 10/20/25
(Date of signature)

[Signature]
(Signature of Provider)

10/20/25
(Date of signature)

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

X-Ray Consent Form

Parent Consent To X-Ray:

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X Signed:  Date: 10/20/2025

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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
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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

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301
(570) 431-9721 / (570) 209-5771 FAX
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: BAUTISTA SOLANO MANUEL

DATE OF BIRTH: 11/20/1994

ID/MRN: 20251020151541077

CLINICIAN: DENNY XAVIER, RODRIGUEZ.MD

FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC

DATE OF EXAM: 10/20/2025

HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER, M25.561-PAIN IN RIGHT KNEE, M25.562-PAIN IN LEFT KNEE

SPINE THORACIC X-RAY 2 view:

COMPARISON:

None

BONES:

No acute fracture or focal osseous lesion.

Bony alignment is anatomic.

DISCS/DEGENERATIVE CHANGES:

The disc spaces are preserved.

SOFT TISSUES:

The adjacent soft tissues appear normal.

IMPRESSION:

No acute osseous process.

RIGHT SHOULDER X-Ray Complete 2 or more views:

COMPARISON:

None

BONES:

No acute fracture or concerning focal osseous lesion.

JOINTS:

No dislocation. The joint spaces are normal.

SOFT TISSUES:

The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

LEFT KNEE X-Ray - 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.

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.

Electronically Signed By: Dr. Asif Anwar M.D. 10/21/2025 20:06:52 EDT

Tech: Dynamic Mobile Xray Services LLC



DYNAMIC
MOBILE XRAY SERVICES LLC

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

Email: dynamjcmobilexrays@gmail.com
website: dynamjcmobilexray.com

MOBILE-PORTABLE X-RAY ORDER FORM

DATE 10/20/25

YOUR INFORMATION:

NAME Bautista Solano Manuel D.O.B. 1/20/194 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)

| | | |
|--|---|---|
| <p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY .. Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/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>KNEE 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 & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p>SI JOINTS Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views <input type="checkbox"/> 71120</p> <p>THORACIC 2 views <input type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY 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</p> <p>OTHER _____</p> |
|--|---|---|

REQUESTING PHYSICIAN:

NAME Denny Xavier Rodriguez NPI# 1619033677 FAX RES# 1619033677
 INDICATE REASON FOR STUDY R/O Ex/pain/pathology SIGNATURE _____
 1 to 242152

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.

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10/20/2025

(01061)-Pimentel Carlos

Date of Birth - 03/28/1986 Sex - Male Marital Status - Single

Address: 5 Post Ave #43, New York, NY, 10034

Phone #: (929) 703-3651

Social Security# - 000-00-0000

Employer or Company Name: N/A

Address: N/A

Emergency Name: Cinthia Castillo 929-597-5028

Work Phone #:

Date of Accident - 04/02/2025

Time/Place Accident - 98th St and 3rd Ave

Date of Visit - 04/04/2025

Condition Related to : Auto Accident

Insurance Company : State Farm Insurance Company

Address: P.O. BOX 16170

ATLANTA, GA, 30348

Phone: Fax:

Claim# - 3283Z328R

Claim Address - P.O. Box 106170

Atlanta GA 30348

NF-2 - Yes

Policy Effective Date -

Policy# - 327

Policy holder - De leon Fabio

WCB# -

Carrier case # -

Attorney - Michelle Klafter, P.C. Firm Name - Law Office of Mitchell Klafter p.c.

Attorney Address - 22-15 street 2nd floor Astoria NY 11105

Attorney Phone - 718-465-1160 Fax - Contact Person -

Other Insurance -

Medicare -

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

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

Claim Number: _____

X Carlos Rinaudo, ("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,
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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 Carlos Rinaudo
(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 Carlos Rinaudo
(Signature of Patient)

X 10/20/25
(Date of signature)

[Signature]
(Signature of Provider)

10/20/25
(Date of signature)

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

X-Ray Consent Form

Parent Consent To X-Ray:

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

X Signed: Carlos Bimentel Date: 10-20-2025

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: Carlos Bimentel Date: 10-20-2025

Females: Regarding Possibility of Pregnancy

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DYNAMIC MOBILE XRAY SERVICES LLC

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E STROUDSBURG, PA 18301
(570) 431-9721 / (570) 209-5771 FAX
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: PIMENTEL CARLOS
DATE OF BIRTH: 03/28/1986
ID/MRN: 20251020154512725
CLINICIAN: DENNY XAVIER, RODRIGUEZ.MD
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 10/20/2025
HISTORY: M25.511-PAIN IN RIGHT SHOULDER, M25.561-PAIN IN RIGHT KNEE

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.

Electronically Signed By: Dr. Asif Anwar M.D. 10/21/2025 20:07:04 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 10/20/25

YOUR INFORMATION:

NAME Pimentel Carlos D.O.B. 3/28/86 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (UA) _____ ADDRESS (UA) _____ 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 type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610 BONE AGE 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/tordotic 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 _____ |
|---|--|--|

REQUESTING PHYSICIAN:

NAME Denny Xavier Rodriguez NPI# 1619033677 FAX RESULTS 1619033677
 INDICATE REASON FOR STUDY R/O Jx/pain/pathology SIGNATURE Denny Xavier Rodriguez MD
 LIC # 242152

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.

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10/20/2025

(01109)-Mota Sandy M

Date of Birth - 05/25/1985 Sex - Male Marital Status - Single

Address: 3125 Park Ave #19A, Bronx, NY, 10451

Phone #: (347) 265-0726

Social Security# - 126-69-2102

Employer or Company Name: n/a

Address: n/a

Emergency Name:

Work Phone #:

Date of Accident - 09/11/2025

Time/Place Accident - Webster Ave & Clay Ave

Date of Visit - 09/16/2025

Condition Related to : Auto Accident

Insurance Company : State Farm Insurance Company

Address: P.O. BOX 16170

ATLANTA, GA, 30348

Phone: Fax:

Claim# - 32-90H0-76D

Claim Address - P.O BOX 52250

PHOENIX AZ

Policy Effective Date -

Policy# - 293-0997-A15-32F-001

Policy holder -

WCB# -

Carrier case # -

Attorney - Michelle Klafter, P.C. Firm Name - Law Office of Mitchell Klafter p.c.

Attorney Address - 22-15 street 2nd floor Astoria NY 11105

Attorney Phone - 718.721.5740 Fax - 718.465.1160

Contact Person -

Other Insurance -

Medicare -

DYNAMIC MOBILE XRAY SERVICES LLC

3412 BLUESTONE LANE
E STROUDSBURG, PA 18301
(570) 431-9721 / (570) 209-5771 FAX
dynamicmobilexrays@gmail.com

Radiology Interpretation

PATIENT NAME: MOTA SANDY**DATE OF BIRTH:** 05/25/1985**ID/MRN:** 20251020141938539**CLINICIAN:** DENNY XAVIER, RODRIGUEZ.MD**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC**DATE OF EXAM:** 10/20/2025**HISTORY:** M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER, M25.562-PAIN IN LEFT KNEE, M79.671-PAIN IN RIGHT FOOT

SPINE THORACIC X-RAY 2 view:

Comparison: None

FINDINGS:

Multiple views of the thoracic spine demonstrate normal alignment.

There are no acute fractures or subluxations of the thoracic spine.

The vertebral body heights and disc spaces are grossly preserved.

The soft tissues are unremarkable.

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

IMPRESSION:**No acute fracture or subluxation of the thoracic spine.**

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.**

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.

RIGHT FOOT X-Ray Complete 3 view:

Comparison: None

FINDINGS:

Multiple views of the right foot show normal alignment without acute fractures or dislocations. A plantar calcaneal enthesophyte is present.

The toe interphalangeal joints, tarsometatarsal joints, metatarsophalangeal joints and subtalar joint are unremarkable.

The talar dome is normal.

There is no soft tissue swelling.

No joint effusion is present.

No radiopaque foreign bodies are seen.

There is no soft tissue gas or osseous erosive changes noted.

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

IMPRESSION:

No acute fracture or dislocation of the right foot.

Electronically Signed By: Dr. Lan Vu M.D. 10/21/2025 20:15:06 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 10/20/25

YOUR INFORMATION:

NAME Mota Sandy D.O.B. 5/25/85 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)

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| 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 type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610 BONE AGE 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/lordotic 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 checked="" 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 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 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"/> 70180 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 2 views..... <input checked="" 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 _____ |
|---|--|---|

REQUESTING PHYSICIAN:

NAME Denny Xavier Rodriguez NPI# 1619033677 FAX RESULTS 1619033677
 INDICATE REASON FOR STUDY W/o fx/pain/pathology SIGNATURE Denny Xavier Rodriguez MD
 Lic 242152

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.

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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, Standy, ("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 Standy MORA
(Print name of Patient)

(Address 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 10/20/25
(Date of signature)

[Signature]
(Signature of Provider)

10/20/25
(Date of signature)

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

X-Ray Consent Form

Parent Consent To X-Ray:

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

X Signed: *[Signature]* Date: 10/20/2025

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: _____