

Extremity
T-PRY

SIGN IN SHEET

Dr. M Chiropractic, PC
2354 Westchester Ave
The Bronx, NY 10462
Phone: (718) 684-4535
Fax: (718) 684-4536

PLEASE PRINT YOUR NAME

DATE: 11/19/25

1	Nicola Gulex	26	
2	Medina Benjamin	27	
3	Joyner Julius	28	
4	Jessica Rosario	29	
5	Samuel Garcia	30	
6	Luis Cruz	31	
7	Spartaco Michael	32	
8	Augustin Jerry	33	
9	German Lissette	34	
10	Ynoa Rafael	35	
11	Diaz Taveres	36	
12	Bue Frank	37	
13		38	
14		39	
15		40	
16		41	
17		42	
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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 Frank Buc ("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 Frank Buc
(Print name of Patient)

X [Signature]
(Signature of Patient)

X 11/19/2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

11/19/2025
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301

X-Ray Consent Form

Patient 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 time I know of no other condition which the taking of x-rays would further complicate.

Signed: _____

[Handwritten Signature]

Date: _____

11/19/25

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 time I know of no other condition which the taking of x-rays would further complicate.

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.

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: BUIE FRANK
DATE OF BIRTH: 04/08/1990
ID/MRN: 2025111917104386A
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/19/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.561-PAIN IN RIGHT KNEE, M25.562-PAIN IN LEFT KNEE

SPINE THORACIC X-RAY 2 view:

Thoracic: AP, lateral views of the thoracic spine. No prior studies. There is normal alignment without fracture. Mineralization is normal. Vertebral body heights are preserved. Disc spaces and posterior elements are normal. No erosive or destructive changes.

IMPRESSION:

No thoracic fracture or subluxation.

LEFT KNEE X-Ray - 1-2 view:

Knee: Frontal and lateral views of the left knee submitted. No prior study for comparison. There is no acute fracture or dislocation. Joint spaces normal. No plain film evidence for osteochondral defect. Mineralization is normal. There is no suprapatellar effusion.

IMPRESSION:

No acute knee fracture or dislocation.

RIGHT KNEE X-Ray - 1-2 view:

Knee: Frontal and lateral views of the right knee submitted. No prior study for comparison. There is no acute fracture or dislocation. Joint spaces normal. No plain film evidence for osteochondral defect. Mineralization is normal. There is no suprapatellar effusion.

IMPRESSION:

No acute knee fracture or dislocation.

Electronically Signed By: Dr. Derek Urban 11/20/2025 16:57:31 EST

Tech: Dynamic Mobile Xray Services LLC

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: BUJE FRANK
DATE OF BIRTH: 04/08/1990
ID/MRN: 20251119171043860
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/19/2025
HISTORY: RIBS PAIN / Z11.1-ENCOUNTER FOR SCREENING FOR RESPIRATORY TUBERCULOSIS

CRITICAL FINDINGS

Chest X-Ray 2V:

Bullous emphysematous changes noted bilaterally. No definite infiltrates noted. CT may be advised for further evaluation. TB can neither be established nor excluded on the present study.

IMPRESSION:

Extensive bullous emphysematous changes noted. Heart is normal size. Correlation with CT scan is advised. Pneumothorax can not be excluded.

Electronically Signed By: Steven Brownstein MD 11/19/2025 19:59:12 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/19/25

YOUR INFORMATION:

NAME Sue Frank D.O.B. 4/8/90 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"/> 74008 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 view <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input checked="" type="checkbox"/> 71046 Complete w/lordotic 3 views <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES.. Complete 3 or more views <input type="checkbox"/> 70150</p> <p>FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND Complete 3 views - R <input type="checkbox"/> <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input 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 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 7 views <input checked="" type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY</p> <p>EXTREMITY Lower. 2 views <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS .. min. 2 views <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME DR. SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO () _____
 INDICATE REASON FOR STUDY no pathology/pain fix SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN Osamu Auebor TECHNIQUE FSKY/SMMS # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/19/25 PATIENT ID # NA # OF CD NA

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.

5+X



PATIENT DEMOGRAPHIC FORM 11/19/2025

YNOA, RAFAEL

DOB: 05/04/1980

Cell Phone: 646-339-8821

Sex: Male

Home phone:

DOA: 04/23/2025

Social Security Number:

Case type: No Fault

Address: 38 VINEYARD AVENUE APT 1, Yonkers, NY, 10703

Primary Insurance: STATE FARM INS

Address: PO BOX 106170, Atlanta, GA, 30348

Claim Number: 5284M723J

Policy Number:

Policy Holder: YNOA, RAFAEL

Phone Number:

Fax:

Carrier Case:

WCB Case:

*T
R
R - fore Arm
K - knee
Shoulder*

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney:

Address:

Phone number:

WC Attorney: THE CHERNY LAW OFFICE

Address: 171 Westwood Ave fl.1, Staten Island, NY, 10314

Phone number: 718-494-7100

Referring Doctor:

Referring Office:

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

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

Claim Number: _____

X Ra Ra el ynoa, ("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 Ra Ra el ynoa
(Print name of Patient)

X Robert ynoa
(Signature of Patient)

X 11/19/2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

11/19/2025
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC

**3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301**

X-Ray Consent Form

Patient 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 time I know of no other condition which the taking of x-rays would further complicate.

Signed: Robert yoo Date: 11/19/25

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 time I know of no other condition which the taking of x-rays would further complicate.

Signed: Robert yoo Date: 11/19/25

Females: Regarding Possibility of Pregnancy

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

Signed: Robert yoo Date: 11/19/25

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: YNOA RAFEAL
DATE OF BIRTH: 05/04/1980
ID/MRN: 20251119120342419
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/19/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M79.631-PAIN IN RIGHT FOREARM, M25.562-PAIN IN LEFT KNEE

SIGNIFICANT FINDINGS

SPINE THORACIC X-RAY 2 view:

Indication: Pain in thoracic spine, pain in right forearm, pain in left knee.

Technique: Two views thoracic spine

Comparison: None

Findings: Mild degenerative changes in the thoracic spine. There is preservation of the vertebral body heights and disc spaces. There is preservation of the normal thoracic kyphosis.

IMPRESSION:

Minimal degenerative change in the thoracic spine. The study is otherwise unremarkable.

RIGHT FOREARM X-RAY 2V:

Indication: Pain in right forearm

Technique: 3 views- forearm

Comparison: None

Findings:

There are no fractures or dislocations identified. The radiocarpal joint is narrowed. The elbow joint is within normal limits. The bone mineralization is within normal limits. No soft tissue masses are present.

IMPRESSION:

No evidence of acute fracture or dislocation.

LEFT KNEE X-Ray - 1-2 view:

Indication: Left Knee pain

Technique: Two views the study is degraded by motion artifacts.

Comparison: None

Finding:

The tibiofemoral, the patellofemoral and the proximal tibiofibular joints are in anatomic alignment. Joint spaces are preserved. There is ossification at the insertion site of the quadriceps tendon.

No demonstrated joint effusion in the suprapatellar bursa. The soft tissues of the extensor mechanism appear normal.

Periarticular soft tissues are normal.

IMPRESSION:

Negative radiographs-- Left-knee

Electronically Signed By: Dr. Ceceleta Maitland M.D. 11/20/2025 16:36:21 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/19/25

YOUR INFORMATION:

NAME YN09 Lafael D.O.B. 5/4/80 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 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 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 checked="" type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND Complete 3 views - R <input type="checkbox"/> ... <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> ... <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> ... <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input 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 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</p> <p>EXTREMITY Lower. 2 views <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS .. min. 2 views <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME DR. SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO _____
 INDICATE REASON FOR STUDY no pathology/pain fix SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN Osamu Aguebor TECHNIQUE FSK4/5MAB # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/19/25 PATIENT ID # 124 # OF CD 104

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.

EXT

PATIENT DEMOGRAPHIC FORM 11/19/2025

ROSARIO, JESSICA

DOB: 10/09/1988

Cell Phone: 347-925-4692

Sex: Female

Home phone:

DOA: 08/03/2025

Social Security Number:

Case type: No Fault

Address: 8020 BAY PKWAY APT B33, Brooklyn, NY, 11214

Primary Insurance: GEICO

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

Claim Number: 0602789290101041

Policy Number:

Policy Holder: RIVERA, MICHEAL

Phone Number:

Fax:

Carrier Case:

WCB Case:

T. Sharkey

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: THE LAW OFFICES OF ALMONTE LITIGATION GROUP P.C

Address: 69 STRATFORD ROAD 2ND FL, Ste: 1A, Brooklyn, NY, 11218

Phone number: 718-450-3909

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

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

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

Claim Number: _____

X I, Jessica K Rosario, ("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 Jessica Robin Rosario
(Print name of Patient)

Jessica Robin Rosario
(Signature of Patient)
11/19/2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)
11/19/2025
(Date of signature)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301

X-Ray Consent Form

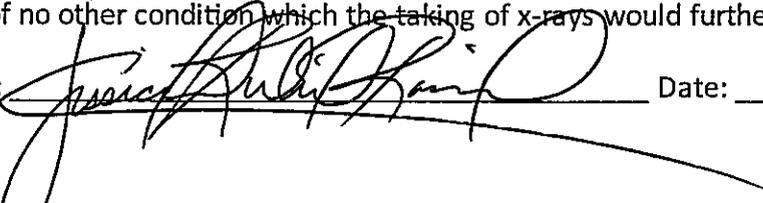
Patient Consent To X-Ray:

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

Signed:  Date: _____

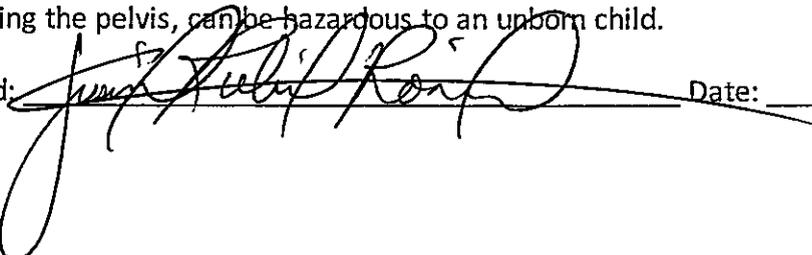
Consent To X-Ray:

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 time I know of no other condition which the taking of x-rays would further complicate.

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.

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: JESSICA ROSARIO
DATE OF BIRTH: 10/09/1988
ID/MRN: 20251119140337880
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/19/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER

SPINE THORACIC X-RAY 2 view:

Examination: Radiographs of the thoracic spine
Comparison study: None
Findings:
There is normal alignment of the thoracic spine without scoliosis.
The vertebral body heights and intervertebral disc spaces are well-maintained.
No evidence of compression fracture or disc space infection.
There is normal bony mineralization.

IMPRESSION:

1. Normal thoracic spine series.

RIGHT SHOULDER X-Ray Complete 2 or more views:

Examination: Radiographs of the shoulder
Comparison study: None
Findings:
Views of the shoulder demonstrate normal bony mineralization.
There is no evidence of Hill-Sachs fracture or dislocation.
The bony glenoid and a.c. Joint space are well-maintained.
The visualized ribs and proximal humerus are intact.

IMPRESSION:

1. No acute skeletal or soft tissue injury.

Electronically Signed By: Dr. Walter Uyesugi M.D. 11/20/2025 17:06:22 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/19/25

YOUR INFORMATION:

NAME Jessica Vasquez D.O.B. 10/19/88 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

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

NAME DR. SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO () _____
 INDICATE REASON FOR STUDY no pathology/pain/px SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN Osamu Aguebor TECHNIQUE 75kV/5mAs # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/19/25 PATIENT ID # NA # OF CD NA

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.

Ext

EAT



PATIENT DEMOGRAPHIC FORM 11/19/2025

NICOLAS, GUILIX

DOB: 06/01/1999

Cell Phone: 347-595-3676

Sex: Male

Home phone:

DOA: 05/10/2025

Social Security Number:

Case type: No Fault

Address: 425 EAST 110 STREET APT 1051, New York, NY, 10

Primary Insurance: GEICO

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

Claim Number: 8829284790000002

Policy Number:

Policy Holder: MERZIER, DOOLEY

Phone Number:

Fax:

Carrier Case:

WCB Case:

*T
R
Shoulder*

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: SURDEZ PEREZ

Address: 3272 Steinway Street Suite 401, Astoria, NY, 11103

Phone number: 718-482-1555

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office: 2354 Chiropractic PC

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

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

Claim Number: _____

X Guilex Nicolas ("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 Guilex Nicolas
(Print name of Patient)

X Guilex Nicolas
(Signature of Patient)

X 11/19/2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

11/19/2025
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301

X-Ray Consent Form

Patient 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 time I know of no other condition which the taking of x-rays would further complicate.

Signed: Guillex Nisole Date: 11/19/25

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 time I know of no other condition which the taking of x-rays would further complicate.

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.

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: NICOLAS GUILIX
DATE OF BIRTH: 06/01/1999
ID/MRN: 20251119165147337
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/19/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER

SIGNIFICANT FINDINGS

SPINE THORACIC X-RAY 2 view:

Findings: Evaluation of the thoracic spine was performed.
Mild diffuse degenerative changes.
No fracture evident.
The soft tissues appear within range of normal.

IMPRESSION:

Degenerative changes.
No evidence of acute fracture

RIGHT SHOULDER X-Ray Complete 2 or more views:

Findings: Mild diffuse degenerative changes.
Fracture felt to be subacute distal clavicle.
No dislocation.
Soft tissues appear unremarkable.

IMPRESSION:

Subacute distal clavicle fracture. Correlation with clinical history suggested.

Electronically Signed By: Dr. James Collins M.D. 11/20/2025 16:45:07 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/19/25

YOUR INFORMATION:

NAME Nicolas Quiret D.O.B. 01/19 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 type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES .. Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views <input type="checkbox"/> 70360</p> <p>ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p>SI JOINTS Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views <input type="checkbox"/> 71120</p> <p>THORACIC 2 views <input checked="" type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY 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>
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REQUESTING PHYSICIAN:

NAME DR. SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO _____
 INDICATE REASON FOR STUDY No pathology/pain/px SIGNATURE [Signature]

FOR OFFICE USE ONLY:

TECHNICIAN Osamu Aguebor TECHNIQUE FSK4/SMMS # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/19/25 PATIENT ID # N/A # OF CD N/A

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.

Est.



PATIENT DEMOGRAPHIC FORM 11/19/2025

MEDINA, BENJAMIN

DOB: 03/31/1980 Cell Phone: 646-973-7760
Sex: Male Home phone:
DOA: 06/14/2025 Social Security Number:
Case type: No Fault
Address: 303 SAINT ANNS AVE APT 6, Bronx, NY, 10454

Primary Insurance: GEICO
Address: P.O. BOX 9507, Fredericksburg, VA, 22403
Claim Number: 0662614100000001
Policy Number: 4596025934
Policy Holder: HARLEN, M, SILVA-TORRES
Phone Number: 516-714-7494
Fax:
Carrier Case:
WCB Case:

R. Sholder

Secondary Insurance:
Address:
Claim Number:
Policy Number:
Policy Holder:
Phone Number:
Fax:

BI Attorney: STRATFORD LAW GROUP
Address: 69 STRATFORD ROAD FLOOR 2ND FLOOR, Brooklyn, NY, 11218
Phone number: 718-450-3909
WC Attorney:
Address:
Phone number:

Referring Doctor:

Referring Office:

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

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

Claim Number: _____

X BENJAMIN MEDINA, ("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.

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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 [Signature]
(Print name of Patient)

X [Signature]
(Signature of Patient)

(Address of Patient)

X 11/19/2025
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

11/19/2025
(Date of signature)

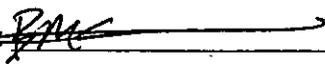
EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301

X-Ray Consent Form

Patient 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 time I know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 11/19/2023

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 time I know of no other condition which the taking of x-rays would further complicate.

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.

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: MEDINA BENJAMIN
DATE OF BIRTH: 03/21/1980
ID/MRN: 20251119160236099
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/19/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER

SPINE THORACIC X-RAY 2 view:

Examination: Radiographs of the thoracic spine
Comparison study: None
Findings:
There is normal alignment of the thoracic spine without scoliosis.
The vertebral body heights are normal without acute fracture.
Mild endplate changes and osteophytosis noted throughout the spine.
No evidence of the disc space infection.
Decreased bony mineralization.

IMPRESSION:

1. Mild spondylosis of the thoracic spine without fracture.

RIGHT SHOULDER X-Ray Complete 2 or more views:

Examination: Radiographs of the shoulder
Comparison study: None
Findings:
Views of the shoulder demonstrate decreased bony mineralization.
There is no evidence of Hill-Sachs fracture or dislocation.
Minimal arthritic changes are noted at the gleno-humeral joint space with sub-acromial joint space narrowing and acromioclavicular joint arthrosis.
The visualized ribs and proximal humerus are intact.

IMPRESSION:

1. Osteoarthritis of the shoulder and A.C. Joint space.

Electronically Signed By: Dr. Walter Uyesugi M.D. 11/20/2025 17:03:26 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/19/25

YOUR INFORMATION:

NAME Melina Benjamin D.O.B. 5/21/80 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 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"/> <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES .. Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views <input type="checkbox"/> 70360</p> <p>ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p>SI JOINTS Complete, 2 views <input type="checkbox"/> 72200</p> <p>SINUSES Limited 2 or less <input type="checkbox"/> 70210 Complete 3+ views <input type="checkbox"/> 70220</p> <p>SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260</p> <p>STERNUM Complete 2 views <input type="checkbox"/> 71120</p> <p>THORACIC 2 views <input checked="" type="checkbox"/> 72072</p> <p>THORACOLUMBAR. 2 views <input type="checkbox"/> 72080</p> <p>TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p>TMJ Bilateral open/closed <input type="checkbox"/> 70330</p> <p>TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p>WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p>INFANT X-RAY</p> <p>EXTREMITY Lower. 2 views <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS .. min. 2 views <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME DR. SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO () _____

INDICATE REASON FOR STUDY No pathology/pain/px SIGNATURE

FOR OFFICE USE ONLY:

TECHNICIAN Osamu Aguebor TECHNIQUE 75kV/5mAs # OF VIEWS _____

X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/19/25 PATIENT ID # NA # OF CD 1/4

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.

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, Julius Baker ("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 Julius Baker
(Print name of Patient)

X Julius Baker
(Signature of Patient)
X 11/19/2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

Julius Baker
(Signature of Provider)
11/19/2025
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301

X-Ray Consent Form

Patient 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 time I know of no other condition which the taking of x-rays would further complicate.

Signed: _____

Date: _____

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 time I know of no other condition which the taking of x-rays would further complicate.

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.

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: JOYNER JULIUS
DATE OF BIRTH: 12/08/1964
ID/MRN: 20251119141209304
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/19/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.512-PAIN IN LEFT SHOULDER

SPINE THORACIC X-RAY 2 view:

Examination: Radiographs of the thoracic spine
Comparison study: None
Findings:
There is normal alignment of the thoracic spine without scoliosis.
The vertebral body heights are normal without acute fracture.
Moderate endplate changes and osteophytosis noted throughout the spine.
No evidence of the disc space infection.
Decreased bony mineralization.

IMPRESSION:

1. Moderate spondylosis of the thoracic spine without fracture.

LEFT SHOULDER X-Ray Complete 2 or more views:

Examination: Radiographs of the shoulder
Comparison study: None
Findings:
Views of the shoulder demonstrate normal bony mineralization.
There is no evidence of Hill-Sachs fracture or dislocation.
The bony glenoid and a.c. Joint space are well-maintained.
The visualized ribs and proximal humerus are intact.

IMPRESSION:

1. No acute skeletal or soft tissue injury.

Electronically Signed By: Dr. Walter Uyesugi M.D. 11/20/2025 17:04:48 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/19/25

YOUR INFORMATION:

NAME Joyner Julius D.O.B. 12/08/64 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE (____) _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

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

NAME DR. SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO (____) _____
 INDICATE REASON FOR STUDY no pathology/pain/fix SIGNATURE

FOR OFFICE USE ONLY:

TECHNICIAN Osamu Auebor TECHNIQUE FSKY/SMMS # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/19/25 PATIENT ID # N/A # OF CD N/A

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.

6-14

PATIENT DEMOGRAPHIC FORM 11/19/2025

GARCIA-MELO, SAMUEL

DOB: 05/27/1999

Cell Phone: 917-708-4001

Sex: Male

Home phone:

DOA: 07/16/2025

Social Security Number: 015-35-9421

Case type: No Fault

Address: 216 E 203RD STREET APT4A, Bronx, NY, 10458

Primary Insurance: BRISTOL WEST INSURANCE COMPANY

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

Claim Number: 7009200993-1

Policy Number:

Policy Holder: ELIAS-ACOSTA, IZULEYMA

Phone Number:

Fax:

Carrier Case:

WCB Case:

T - [scribble] (R)
Shou [scribble] (R)
Wice (R)

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: Lozner & Mastropietro Law Office

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

Phone number: 718-615-0044

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

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, SAMUEL, ("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 SAMUEL
(Print name of Patient)

X [Signature]
(Signature of Patient)

X 11/19/2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

11/19/2025
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301

X-Ray Consent Form

Patient 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 time I know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 11/19/25

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 time I know of no other condition which the taking of x-rays would further complicate.

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.

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: SAMUEL GARCIA-MELO

DATE OF BIRTH: 05/27/1999

ID/MRN: 20251119132128413

CLINICIAN: SCARBOROUGH, PAUL. DR

FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC

DATE OF EXAM: 11/19/2025

HISTORY: M25.512-PAIN IN LEFT SHOULDER, M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER, M25.561-PAIN IN RIGHT KNEE

SPINE THORACIC X-RAY 2 view:

Examination: Radiographs of the thoracic spine

Comparison study: None

Findings:

There is normal alignment of the thoracic spine without scoliosis.
The vertebral body heights and intervertebral disc spaces are well-maintained.
No evidence of compression fracture or disc space infection.
There is normal bony mineralization.

IMPRESSION:

1. Normal thoracic spine series.

LEFT SHOULDER X-Ray Complete 2 or more views:

Examination: Radiographs of the shoulder

Comparison study: None

Findings:

Views of the shoulder demonstrate normal bony mineralization.
There is no evidence of Hill-Sachs fracture or dislocation.
The bony glenoid and a.c. Joint space are well-maintained.
The visualized ribs and proximal humerus are intact.

IMPRESSION:

1. No acute skeletal or soft tissue injury.

RIGHT SHOULDER X-Ray Complete 2 or more views:

Examination: Radiographs of the shoulder

Comparison study: None

Findings:

Views of the shoulder demonstrate normal bony mineralization.
There is no evidence of Hill-Sachs fracture or dislocation.
The bony glenoid and a.c. Joint space are well-maintained.
The visualized ribs and proximal humerus are intact.

IMPRESSION:

1. No acute skeletal or soft tissue injury.

RIGHT KNEE X-Ray - 1-2 view:

Examination: Radiographs of the knee

Comparison study: None

Findings:

Routine views of the knee demonstrate normal bony mineralization.

There is no evidence of acute fracture, dislocation or joint effusion.

Surrounding soft tissues are within normal limits.

No evidence of osteomyelitis.

IMPRESSION:

1. No acute skeletal or soft tissue injury.

Thank you for allowing me to participate in the care of your patient.

Electronically Signed By: Dr. Walter Uyesugi M.D. 11/20/2025 17:10:00 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/19/25

YOUR INFORMATION:

NAME Samuel Garcia Melo D.O.B. 12/19 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 view..... <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>KNÉE 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 & 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 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 Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME DR. SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO () _____
 INDICATE REASON FOR STUDY no pathology/pain/tx SIGNATURE [Signature]

FOR OFFICE USE ONLY:

TECHNICIAN Osamu Aguebor TECHNIQUE 75kV/5mAs # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/19/25 PATIENT ID # N/A # OF CD N/A

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.

Exx



PATIENT DEMOGRAPHIC FORM 11/19/2025

DE JESUS DE LA CRUZ, LUIS

DOB: 07/28/1991 Cell Phone: 347-940-8225
Sex: Male Home phone:
DOA: 06/27/2025 Social Security Number: 115-63-9024
Case type: No Fault
Address: 1083 ALTON AVENUE APT 45, Bronx, NY, 10452

Primary Insurance: GEICO
Address: P.O. BOX 9507, Fredericksburg, VA, 22403
Claim Number: 8827099270000001
Policy Number: 6177-54-54-64
Policy Holder: PINA DEL ROSARIO, YABELL
Phone Number:
Fax:
Carrier Case:
WCB Case:

J
R - Hand
R - Foot

Secondary Insurance:
Address:
Claim Number:
Policy Number:
Policy Holder:
Phone Number:
Fax:

BI Attorney: THE LAW OFFICES OF ALMONTE LITIGATION GROUP P.C
Address: 69 STRATFORD ROAD 2ND FL, Ste: 1A, Brooklyn, NY, 11218
Phone number: 718-450-3909
WC Attorney:
Address:
Phone number:

Referring Doctor:

Referring Office:

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

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

Claim Number: _____

X Luis Chamuel De Jesus De la Cruz ("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 06/27/2025, not withstanding any other agreement
(Print accident date)
to the contrary.

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

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

X Luis Chamuel De Jesus De la Cruz
(Print name of Patient)

X Luis Chamuel De Jesus De la Cruz
(Signature of Patient)

X 11/19/2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

11/19/2025
(Date of signature)

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301

X-Ray Consent Form

Patient 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 time I know of no other condition which the taking of x-rays would further complicate.

Signed: Luis Chamuel de Jesus de la Cruz Date: 11/19/2025

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 time I know of no other condition which the taking of x-rays would further complicate.

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.

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: LUIS DE JESUS DE LA CRUZ
DATE OF BIRTH: 07/28/1991
ID/MRN: 20251119131414823
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/19/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M79.641-PAIN IN RIGHT HAND, M79.671-PAIN IN RIGHT FOOT

SPINE THORACIC X-RAY 2 view:

Examination: Radiographs of the thoracic spine
Comparison study: None
Findings:
There is normal alignment of the thoracic spine without scoliosis.
The vertebral body heights are normal without acute fracture.
Mild endplate changes and osteophytosis noted throughout the spine.
No evidence of the disc space infection.
Decreased bony mineralization.

IMPRESSION:

1. Mild spondylosis of the thoracic spine without fracture.

RIGHT HAND X-Ray - 3 view:

Examination: Radiographs of the hand
Comparison study: None
Findings:
The hand demonstrates decreased bony mineralization.
There is no evidence of acute fracture, or dislocation.
Minimal arthritic changes noted throughout the hands and digits primarily at the PIPJ and DIPJ's.
No significant soft tissue swelling is identified. No evidence of osteomyelitis.

IMPRESSION:

1. Mild arthritic changes of the hand without acute fracture.

RIGHT FOOT X-Ray - 2 view:

Examination: Radiographs of the foot.
Comparison study: None
Findings:
There is normal bony mineralization of the foot.
There is no evidence of fracture, dislocation or arthritic change.
The surrounding soft tissues are within normal limits.
No evidence of osteomyelitis.
No evidence of hallux valgus or hammertoe deformity.

IMPRESSION:

1. No acute bony injury at the foot.

Electronically Signed By: Dr. Walter Uyesugi M.D. 11/20/2025 17:11:30 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/19/25

YOUR INFORMATION:

NAME Wes de Jesus Cruz D.O.B. 7/28/91 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE (____) _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY .. Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views . <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES.. Complete 3 or more views..... <input type="checkbox"/> 70150</p> <p>FEMUR..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # . Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 2 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 checked="" type="checkbox"/> <input type="checkbox"/> 73130</p> <p>HEEL..... Complete 2 views - R <input type="checkbox"/> <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views..... <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views..... <input type="checkbox"/> 72114 Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views..... <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES .. Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views..... <input type="checkbox"/> 70360</p> <p>ORBITS..... Complete 4 views..... <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views Includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views..... <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS..... 3 views..... <input type="checkbox"/> 71130</p> <p>SHOULDER Complete, 2 views - R <input type="checkbox"/> L <input 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 Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME DR. SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO (____) _____
 INDICATE REASON FOR STUDY no pathology/pain fix SIGNATURE [Signature]

FOR OFFICE USE ONLY:

TECHNICIAN Osahin Aguebor TECHNIQUE FSKY/SMMS # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/19/25 PATIENT ID # N/A # OF CD N/A

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.

ETX

PATIENT DEMOGRAPHIC FORM 11/19/2025

SPATARO, MICHAEL

DOB: 10/14/1994

Cell Phone: 929-500-6448

Sex: Male

Home phone:

DOA: 10/01/2025

Social Security Number:

Case type: No Fault

Address: 123 S 8TH AVE FL 3, Mount Vernon, NY, 10550

Primary Insurance: PROGRESSIVE INS

Address: 725 BROADWAY, Albany, NY, 12207

Claim Number: 25-375765644

Policy Number:

Policy Holder: DIAZ-TAVEREZ, LUILLY

Phone Number:

Fax:

Carrier Case:

WCB Case:

*T - Spataro
K - Kwee*

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: Lozner & Mastropietro Law Office

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

Phone number: 718-615-0044

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office: 2354 Chiropractic PC

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

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

Claim Number: _____

X L. MICHAEL SPATARO ("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 10-01-2025, not withstanding any other agreement
(Print accident date)
to the contrary.

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

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

X MICHAEL SPATARO
(Print name of Patient)

1235 SOUTH 8 AVE MOUNT VERNON

BRONX NY 10550
(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 11/19/2025
(Date of signature)

[Signature]
(Signature of Provider)

11/19/2025
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301

X-Ray Consent Form

Patient 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 time I know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 11-19-2025

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 time I know of no other condition which the taking of x-rays would further complicate.

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.

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: SPATARO MICHEAL
DATE OF BIRTH: 10/14/1994
ID/MRN: 20251119130313130
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/19/2025
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:

Indication: Pain in thoracic spine.

Technique: Two views thoracic spine

Comparison: None

Findings:

There is preservation of the normal thoracic kyphosis, vertebral body heights and disc spaces. Minimal osteophytes are present. There are no acute fractures or subluxations.

The visualized lung fields are clear. The heart size is within normal limits. No pneumothorax is identified in the visualized lung fields.

IMPRESSION:

No significant abnormality in the thoracic spine.

LEFT SHOULDER X-Ray Complete 2 or more views:

Indication: Pain in left shoulder

Technique: 2 views left shoulder joint

Comparison: None

Findings: The gleno-humeral joint is in normal anatomic alignment.

Joint space is preserved. No acute bony or joint space abnormality. No erosive or productive arthropathy.

The AC joint is in normal alignment. The acromion is normal. The sub-acromial space is normal.

No lytic or blastic lesions in the visualized proximal humerus and upper ribcage.

Periarticular soft tissues are normal

IMPRESSION:

Negative radiographs left shoulder joint

LEFT KNEE X-Ray - 1-2 view:

Indication: Left Knee pain

Technique: Two views

Comparison: None

Finding:

The study is degraded by motion artifacts.

The tibiofemoral, the patellofemoral and the proximal tibiofibular joints are in anatomic alignment. Joint spaces are preserved.

There is no erosive or productive arthropathy or erosive bone lesions.

No demonstrated joint effusion in the suprapatellar bursa. The soft tissues of the extensor mechanism appear normal.

Periarticular soft tissues are normal.

IMPRESSION:

Negative radiographs- Left-knee

Electronically Signed By: Dr. Ceceleta Maitland M.D. 11/20/2025 18:32:59 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/19/25

YOUR INFORMATION:

NAME SPATAVO Michew D.O.B. 10/14/94 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 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"/> 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</p> <p>EXTREMITY Lower. 2 views <input type="checkbox"/> 73592</p> <p>EXTREMITY Upper. 2 views <input type="checkbox"/> 73092</p> <p>PELVIS & HIPS .. min. 2 views <input type="checkbox"/> 73540</p> <p>WRIST Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME DR. SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO _____
 INDICATE REASON FOR STUDY R/O pathology/pain/fix SIGNATURE

FOR OFFICE USE ONLY:

TECHNICIAN Osamu Aguebor TECHNIQUE FSK4/SMAS # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/19/25 PATIENT ID # N/A # OF CD N/A

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.

B+x

PATIENT DEMOGRAPHIC FORM 11/19/2025

AUGUSTIN, JERRY

DOB: 09/13/1985

Cell Phone: 929-800-0945

Sex: Male

Home phone:

DOA: 07/12/2025

Social Security Number: 110-70-9646

Case type: No Fault

Address: 1 HARRISON STREET APT 3B, New Rochelle, NY, 1

Primary Insurance: STATE FARM INS

Address: PO BOX 106170, Atlanta, GA, 30348

Claim Number: 32-87Q343S

Policy Number: 360909732A

Policy Holder: RAGHUBAR, KRISHNA

Phone Number: 844-292-8615

Fax:

Carrier Case:

WCB Case:

T
R...

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: THE CHERNY LAW OFFICE

Address: 171 Westwood Ave fl.1, Staten Island, NY, 10314

Phone number: 718-494-7100

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

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

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

Claim Number: _____

X Jerry Augustin, ("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 Jerry Augustin
(Print name of Patient)
1 Harrison St. (3B)
New Rochelle NY 10801
(Address of Patient)

X J Augustin
(Signature of Patient)
X 11/19/2025
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301
(Address of Provider)

[Signature]
(Signature of Provider)
11/19/2025
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301

X-Ray Consent Form

Patient 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 time I know of no other condition which the taking of x-rays would further complicate.

Signed: *J. August* Date: 11/19/2025

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 time I know of no other condition which the taking of x-rays would further complicate.

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.

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: AUGUSTIN JERRY
DATE OF BIRTH: 09/13/1985
ID/MRN: 20251119124931902
CLINICIAN: SCARBOROUGH, PAUL, DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/19/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.551-PAIN IN RIGHT HIP

SPINE THORACIC X-RAY 2 view:

Examination: Radiographs of the thoracic spine

Comparison study: None

Findings:

There is normal alignment of the thoracic spine without scoliosis.
The vertebral body heights and intervertebral disc spaces are well-maintained.
No evidence of compression fracture or disc space infection.
There is normal bony mineralization.

IMPRESSION:

1. Normal thoracic spine series.

RIGHT Hip X-Ray unilateral 2-3 views :

Examination: Radiographs of the hip and pelvis.

Comparison study: None

Findings:

There is mild arthritic changes of the hip with circumferential collar osteophytes and joint space narrowing.
No obvious displaced or impacted fracture noted at this time.
Bony mineralization is decreased
No evidence of osteomyelitis.
Remainder of the pelvis is grossly intact.

IMPRESSION:

1. Mild arthritic changes of the hip without evidence of obvious fracture.

If there are continued clinical symptoms follow up radiographs are advised in 3 to 5 days as some early nondisplaced hip fractures can be radiographically occult. Arthritic changes can mask a subtle nondisplaced fractures.

Electronically Signed By: Dr. Walter Uyesugi M.D. 11/20/2025 17:19:03 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/19/25

YOUR INFORMATION:

NAME Augustine Jerry D.O.B. 9/15/85 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)

<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 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 & 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 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 Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100 OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME DR. SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO () _____
 INDICATE REASON FOR STUDY R/O pathology/pain/Bx SIGNATURE

FOR OFFICE USE ONLY:

TECHNICIAN Osamu Aguelor TECHNIQUE 75kV / 5mAs # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/19/25 PATIENT ID # N/A # OF CD 1/4

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.

Ext.



PATIENT DEMOGRAPHIC FORM 11/19/2025

GERMAN, LISETTE

DOB: 09/28/1975

Cell Phone: 347-880-2560

Sex: Female

Home phone:

DOA: 10/01/2025

Social Security Number: 154-97-5466

Case type: No Fault

Address: 2094 AMSTERDAN AVE APT 2A, New York, NY, 100

Primary Insurance: PROGRESSIVE INS

Address: 725 BROADWAY, Albany, NY, 12207

Claim Number: 25-375765644

Policy Number:

Policy Holder: DIAZ-TAVEREZ, LUILLY

Phone Number:

Fax:

Carrier Case:

WCB Case:

Handwritten notes:
T ✓
R → Show K

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: Lozner & Mastropietro Law Office

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

Phone number: 718-615-0044

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

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

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

Claim Number: _____

X Yvette Perri ("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 01-10-25, not withstanding any other agreement to the contrary.
(Print accident date)

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

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

X Yvette Perri
(Print name of Patient)

X Yvette Perri
(Signature of Patient)
X 11/19/2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)
11/19/2025
(Date of signature)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC

**3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301**

X-Ray Consent Form

Patient 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 time I know of no other condition which the taking of x-rays would further complicate.

Signed: Lisette Penn Date: 11/19/25

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 time I know of no other condition which the taking of x-rays would further complicate.

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.

Signed: Lisette Penn Date: 11/19/25

DYNAMIC MOBILE XRAY SERVICES LLC

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

1

Radiology Interpretation

PATIENT NAME: GERMAN LISETTE
DATE OF BIRTH: 09/28/1975
ID/MRN: 20251119123705943
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/19/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE

SPINE THORACIC X-RAY 2 view:

Examination: Radiographs of the thoracic spine

Comparison study: None

Findings:

There is normal alignment of the thoracic spine without scoliosis.

The vertebral body heights are normal without acute fracture.

Mild endplate changes and osteophytosis noted throughout the spine.

No evidence of the disc space infection.

Decreased bony mineralization.

IMPRESSION:

1. Mild spondylosis of the thoracic spine without fracture.

Electronically Signed By: Dr. Walter Uyesugi M.D. 11/20/2025 17:21:46 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 11, 19, 25

YOUR INFORMATION:

NAME German Lissette D.O.B. 9, 28, 1955 SS# _____ MALE FEMALE

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

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

PRIMARY INSURANCE NAME _____ INSURANCE ID # _____

SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

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

NAME DR. SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO () _____

INDICATE REASON FOR STUDY No pathology/pain/PT SIGNATURE [Signature]

FOR OFFICE USE ONLY:

TECHNICIAN Osamu Aguebor TECHNIQUE 75kV / 5mAs # OF VIEWS _____

X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11 / 19 / 25 PATIENT ID # N/A # OF CD N/A

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.

EXT



PATIENT DEMOGRAPHIC FORM 11/19/2025

DIAZ-TAVAREZ, LUILLY

DOB: 04/08/1990

Cell Phone: 347-825-0838

Sex: Male

Home phone:

DOA: 10/01/2025

Social Security Number: 657-39-9866

Case type: No Fault

Address: 1775 DAVIDSON AVE APT 5H, Bronx, NY, 10453

Primary Insurance: PROGRESSIVE INS

Address: 725 BROADWAY, Albany, NY, 12207

Claim Number: 25-375765644

Policy Number:

Policy Holder: DIAZ-TAVAREZ, LUILLY

Phone Number:

Fax:

Carrier Case:

WCB Case:

T

R-Shoulder

L/R Knee

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: Lozner & Mastropietro Law Office

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

Phone number: 718-615-0044

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

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

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

Claim Number: _____

X Lilly 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 Lilly Diaz Tavares
(Print name of Patient)

[Signature]
(Signature of Patient)

X 11/19/2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

11/19/2025
(Date of signature)

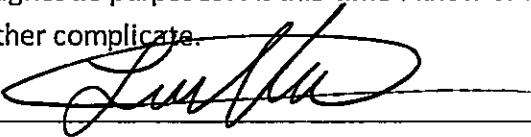
EAST STROUDSBURG PA 18301
(Address of Provider)

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301

X-Ray Consent Form

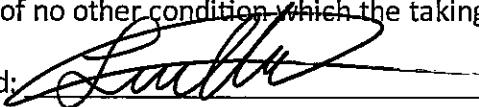
Patient Consent To X-Ray:

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

Signed:  Date: 11/19/2025

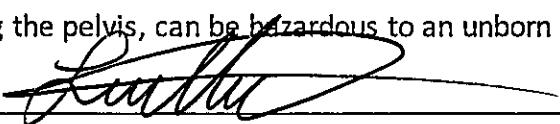
Consent To X-Ray:

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 time I
know of no other condition which the taking of x-rays would further complicate.

Signed:  Date: 11/19/2025

Females: Regarding Possibility of Pregnancy

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

Signed:  Date: 11/19/2025

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: TAVAREZ DIAZ LUILLY**DATE OF BIRTH:** 04/08/1990**ID/MRN:** 20251119114908557**CLINICIAN:** SCARBOROUGH, PAUL. DR**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC**DATE OF EXAM:** 11/19/2025**HISTORY:** M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER, M25.512-PAIN IN LEFT SHOULDER, M25.561-PAIN IN RIGHT KNEE, M25.562-PAIN IN LEFT KNEE

SPINE THORACIC X-RAY 2 view:**Examination:** Radiographs of the thoracic spine**Comparison study:** None**Findings:**

There is normal alignment of the thoracic spine without scoliosis.

The vertebral body heights are normal without acute fracture.

Mild endplate changes and osteophytosis noted throughout the spine.

No evidence of the disc space infection.

Decreased bony mineralization.

IMPRESSION:**1. Mild spondylosis of the thoracic spine without fracture.**

LEFT SHOULDER X-Ray Complete 2 or more views:**Examination:** Radiographs of the shoulder**Comparison study:** None**Findings:**

Views of the shoulder demonstrate decreased bony mineralization.

There is no evidence of Hill-Sachs fracture or dislocation.

Minimal arthritic changes are noted at the gleno-humeral joint space with sub-acromial joint space narrowing and acromioclavicular joint arthrosis.

The visualized ribs and proximal humerus are intact.

IMPRESSION:**1. Osteoarthritis of the shoulder and A.C. Joint space.**

RIGHT SHOULDER X-Ray Complete 2 or more views:**Examination:** Radiographs of the shoulder**Comparison study:** None**Findings:**

Views of the shoulder demonstrate decreased bony mineralization.

There is no evidence of Hill-Sachs fracture or dislocation.

Minimal arthritic changes are noted at the gleno-humeral joint space with sub-acromial joint space narrowing and acromioclavicular joint arthrosis.

The visualized ribs and proximal humerus are intact.

IMPRESSION:

1. Osteoarthritis of the shoulder and A.C. Joint space.

LEFT KNEE X-Ray - 1-2 view:

Examination: Radiographs of the knee

Comparison study: None

Findings:

Routine views of the knee demonstrate decreased bony mineralization.

Mild tri-compartmental osteoarthritic changes are noted with joint space loss and osteophyte formation.

There is no evidence of acute fracture, dislocation or joint effusion.

Surrounding soft tissues are within normal limits.

IMPRESSION:

1. Mild arthritic changes of the knee without acute bony injury.

RIGHT KNEE X-Ray - 1-2 view:

Examination: Radiographs of the knee

Comparison study: None

Findings:

Routine views of the knee demonstrate decreased bony mineralization.

Mild tri-compartmental osteoarthritic changes are noted with joint space loss and osteophyte formation.

There is no evidence of acute fracture, dislocation or joint effusion.

Surrounding soft tissues are within normal limits.

IMPRESSION:

1. Mild arthritic changes of the knee without acute bony injury.

Electronically Signed By: Dr. Walter Uyesugi M.D. 11/20/2025 17:34:48 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/19/25

YOUR INFORMATION:

NAME DIAZ Alvarez Lully D.O.B. 4/8/90 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610</p> <p>BONE AGE 1 view <input type="checkbox"/> 77072</p> <p>BONE SURVEY .. Complete <input type="checkbox"/> 77075</p> <p>CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052</p> <p>CHEST Limited 1 view <input type="checkbox"/> 71045 Complete 2 views <input type="checkbox"/> 71046 Complete w/lordotic 3 views .. <input type="checkbox"/> 71047 Complete 4 views <input type="checkbox"/> 71048 Special views Decubitus <input type="checkbox"/> 71035</p> <p>CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p>ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p>FACIAL BONES.. Complete 3 or more views..... <input type="checkbox"/> 70150</p> <p>FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p>FINGER(S) # .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p>FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p>FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p>HAND Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p>HEEL Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p>HIP Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p>HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p>KNEE Limited 1 or 2 views R <input 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 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 Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME DR. SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO () _____
 INDICATE REASON FOR STUDY no pathology/pain/lfx SIGNATURE

FOR OFFICE USE ONLY:

TECHNICIAN Osamu Aguebor TECHNIQUE FSKY/SMMS # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/19/25 PATIENT ID # N/A # OF CD 1/4

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.