

SIGN IN SHEET

2422 CHIROPRACTIC, PC

2422 KNAPP STREET

BROOKLYN, NY 11235

Phone: 718-758-5757 Fax: 718-758-5759

PLEASE PRINT YOUR NAME

DATE

11/27/25

1	preziosa Thomas	26	
2	rauzindze Sota	27	
3	Zurabashvili Giorgi	28	
4	Benzenishvili Giorgi	29	
5	Kvitsadze Mitchell	30	
6	Mezureshvili Katiaba	31	
7	Blucher Anne	32	
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PATIENT DEMOGRAPHIC FORM 11/24/2025

KAVZINADZE, SHOTA

DOB: 03/09/1976 Cell Phone: 646-573-6686
Sex: Male Home phone:
DOA: 10/28/2025 Social Security Number: 874-83-0932
Case type: No Fault
Address: 2716 BATH AVE, FLOOR 2ND, Brooklyn, NY, 11214

Primary Insurance: Direct Auto Insurance
Address: PO Box 1623, Winston Salem, NC, 27102
Claim Number: 250915808
Policy Number:
Policy Holder: KAVZINADZE, SHOTA
Phone Number:
Fax:
Carrier Case:
WCB Case:

Handwritten notes:
✓
R-Sh
R-Knee
R-Car

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

BI Attorney:
Address:
Phone number:
WC Attorney: KLG - KARASIK LAW GROUP
Address: 1810 Voorhies Avenue, Suite #9, Brooklyn, NY, 11235
Phone number: 718-502-9112

Referring Doctor:
Referring Office: 2422 Knapp St 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 Kaizradze Stokoy, ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS., ("Assignee")
(Print patient's name) (Print hospital or health care provider name)

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

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

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

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

X J. Stokoy
(Print name of Patient)

X [Signature]
(Signature of Patient)
X 11/24/25
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)
11/24/25
(Date of signature)

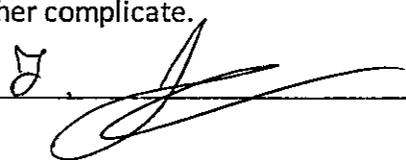
3412 BLUESTONE LANE
EAST STROUDSBURG PA 18301
(Address of Provider)

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: 11/27/25

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: KAVZINADZE SHOTA

DATE OF BIRTH: 03/09/1976

ID/MRN: 20251124163709992

CLINICIAN: SCARBOROUGH, PAUL

FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC

DATE OF EXAM: 11/24/2025

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

SPINE THORACIC X-RAY 2 view:

COMPARISON:

None

BONES:

No acute fracture or focal osseous lesion.

Bony alignment is anatomic.

DISCS/DEGENERATIVE CHANGES:

The disc spaces are preserved. Mild marginal osteophyte formation

SOFT TISSUES:

The adjacent soft tissues appear normal.

IMPRESSION:

No acute osseous process.

LEFT SHOULDER X-Ray Complete 2 or more views:

COMPARISON:

None

BONES:

No acute fracture or concerning focal osseous lesion.

JOINTS:

No dislocation. The joint spaces are normal.

SOFT TISSUES:

The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

RIGHT SHOULDER X-Ray Complete 2 or more views:

COMPARISON:

None

BONES:

No acute fracture or concerning focal osseous lesion.

JOINTS:

No dislocation. The joint spaces are normal.

SOFT TISSUES:

The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

RIGHT KNEE X-Ray - 1-2 view:

COMPARISON:

None

BONES:

No acute fracture or concerning focal osseous lesion.

JOINTS:

No dislocation. The joint spaces are normal.

SOFT TISSUES:

The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

Electronically Signed By: Dr. Asif Anwar M.D. 11/28/2025 11:47:00 EST

Tech: Dynamic Mobile Xray Services LLC



DYNAMIC
MOBILE XRAY SERVICES LLC

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

Email: dynamicmobilexrays@gmail.com
website: dynamajcmobilexray.com

MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/24/25

YOUR INFORMATION:

NAME KAVZIN AYDE SAOHA D.O.B. 3/9/76 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE (____) _____
 FACILITY (IF APPLICABLE) _____ ROOM# (0A) _____ ADDRESS (0A) _____ 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>BONEAGE 1 view <input type="checkbox"/> 77072 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/lex & 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"/> 73520 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"/> 73050</p> <p><u>KNEE</u> Limited 1 or 2 views R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p>LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obl <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views .. <input type="checkbox"/> 72120</p> <p>MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110</p> <p>MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES .. Comp. min. 3 views <input type="checkbox"/> 70160</p> <p>NECK Soft tissue 2 views <input type="checkbox"/> 70360</p> <p>ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030</p> <p>PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170</p> <p>RIBS Unilateral 2 views <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views <input type="checkbox"/> 71110 4 views includes PA chest <input type="checkbox"/> 71111</p>	<p>SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220</p> <p>SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p>SC JOINTS 3 views <input type="checkbox"/> 71130</p> <p><u>SHOULDER</u> Complete, 2 views - R <input checked="" type="checkbox"/> L <input 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><u>THORACIC</u> 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 Uplited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p>OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME DR. PAUL SCARBOROUGH NPI# _____ FAX RESULTS TO _____
 INDICATE REASON FOR STUDY p/o fx/ pathology/ pain SIGNATURE [Signature]

FOR OFFICE USE ONLY:

TECHNICIAN Elson Aquilino TECHNIQUE FS/AL/3MAB # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST yes DATE X-RAY SENT 11/24/25 PATIENT ID # 1111 # OF CD 1/11

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

PATIENT DEMOGRAPHIC FORM 11/24/2025

ZURABASHVILI, GIORGI

DOB: 05/31/2000

Cell Phone: 575-777-2220

Sex: Male

Home phone:

DOA: 10/20/2025

Social Security Number:

Case type: No Fault

Address: 1342 E 18TH ST APT.1B, Brooklyn, NY, 11230

Primary Insurance: HEREFORD INS

Address: 36-01 43 AVE 2 FL, Long Island City, NY, 11101

Claim Number: HLV25010592

Policy Number: PCA1352114-1

Policy Holder: ZURABASHVILI, GIORGI

Phone Number:

Fax:

Carrier Case:

WCB Case:

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: KLG - KARASIK LAW GROUP

Address: 1810 Voorhies Avenue, Suite #9, Brooklyn, NY, 11235

Phone number: 718-502-9112

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

T
R-Hand
Chest
Elbow | 4/R

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

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

Claim Number: _____

X Giorgi Zurabashvili ("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 Giorgi Zurabashvili
(Print name of Patient)

X [Signature]
(Signature of Patient)

(Address of Patient)

X 11.24.25
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

11/24/25
(Date of signature)

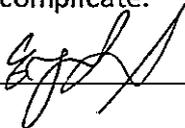
EAST STROUDSBURG PA 18301
(Address of Provider)

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: 3  Date: 11.24.25

Consent To X-Ray:

A Minor I am a parent or legal guardian of _____
who is a minor, _____ years of age. I hereby authorize the performance of diagnostic x-rays of
said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this 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: ZURABASHIVILLI GIORGI
DATE OF BIRTH: 05/31/2000
ID/MRN: 20251124154858035
CLINICIAN: SCARBOROUGH, PAUL
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/24/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.561-PAIN IN RIGHT KNEE

SPINE THORACIC X-RAY 2 view:

Comparison: None

FINDINGS:

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

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

IMPRESSION:

No acute fracture or subluxation of the thoracic spine.

RIGHT KNEE X-Ray - 1-2 view:

Comparison: None

FINDINGS:

Multiple views of the right knee show normal alignment without acute fractures or dislocations.
The medial and lateral tibiofemoral compartments and patellofemoral compartment are unremarkable.
There are no joint bodies.
There is no knee region soft tissue swelling.
There is no joint effusion.
There are no radiopaque foreign bodies.

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

IMPRESSION:

No acute fracture or dislocation of the right knee.

Electronically Signed By: Dr. Lan Vu M.D. 11/28/2025 11:46:30 EST

Tech: Dynamic Mobile Xray Services LLC

PATIENT DEMOGRAPHIC FORM 11/24/2025

BERDZENISHVILI, GIORGI

DOB: 03/10/1987

Cell Phone: 929-729-6020

Sex: Male

Home phone:

DOA: 10/04/2025

Social Security Number:

Case type: No Fault

Address: 1857 85TH STREET, APT 4E, Brooklyn, NY, 11214

Primary Insurance: STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

Address: PO Box 2358, Bloomington, IL, 61702

Claim Number: 3291R145S

Policy Number: 356 5927-E25-32A

Policy Holder: BERDZENISHVILI, GIORGI

Phone Number:

Fax:

Carrier Case:

WCB Case:

*T
sh - R*

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: HOVSEPYAN LAW GROUP

Address: 1111 AVE U 3RD FLOOR, Brooklyn, NY, 11223

Phone number: 718-449-7491

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office: 2422 Knapp St 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: _____

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(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.

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due to the motor vehicle accident which occurred on _____, not withstanding any other agreement
(Print accident date)
to the contrary.

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PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND
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THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

X Giorgi Berdzenishvili
(Print name of Patient)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301
(Address of Provider)

X [Signature]
(Signature of Patient)

X 11/24/25
(Date of signature)

[Signature]
(Signature of Provider)

11/24/25
(Date of signature)

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: BERDZENISHVILLI GIORGI
DATE OF BIRTH: 03/10/1987
ID/MRN: 20251124145559835
CLINICIAN: SCARBOROUGH, PAUL
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/24/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE

SPINE THORACIC X-RAY 2 view:

Comparison: None

FINDINGS:

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

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

IMPRESSION:

No acute fracture or subluxation of the thoracic spine.

Electronically Signed By: Dr. Lan Vu M.D. 11/28/2025 11:46:41 EST

Tech: Dynamic Mobile Xray Services LLC



DYNAMIC
MOBILE XRAY SERVICES LLC

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

Email: dynamicmobilexrays@gmail.com
website: dynamicmobilexray.com

MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/24/25

YOUR INFORMATION:

NAME Heri Zemisshvili Grog D.O.B. 3/10/87 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (DA) _____ ADDRESS (DA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

ABDOMEN..... KUB 1 view..... <input type="checkbox"/> 74000 Complete 2 views..... <input type="checkbox"/> 74020 Acute w/chest 3 views..... <input type="checkbox"/> 74022	HAND..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130 HEEL..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650 HIP..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520 HUMERUS..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060 KNEE..... Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565	SACRUM & COCCYX.. Min. 3 views..... <input type="checkbox"/> 72220 SCAPULA..... 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010 SC JOINTS..... 3 views..... <input type="checkbox"/> 71130 SHOULDER..... Complete, 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73030 SI JOINTS..... Complete, 2 views..... <input type="checkbox"/> 72200 SINUSES..... Limited 2 or less..... <input type="checkbox"/> 70210 Complete 3+ views..... <input type="checkbox"/> 70220 SKULL..... Limited 3 views or less..... <input type="checkbox"/> 70250 Complete 4 views..... <input type="checkbox"/> 70260 STERNUM..... Complete 2 views..... <input type="checkbox"/> 71120 THORACIC..... 5 views..... <input checked="" type="checkbox"/> 72072 THORACOLUMBAR.. 2 views..... <input type="checkbox"/> 72080
AC JOINTS W/ & W/O WEIGHTS 2 views..... <input type="checkbox"/> 73050	LUMBAR..... Limited 2 or 3 views..... <input type="checkbox"/> 72100 Complete 4 views w/obl..... <input type="checkbox"/> 72110 Complete w/bending 7 views..... <input type="checkbox"/> 72114 Limited w/bending 4 views..... <input type="checkbox"/> 72120	TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590
ANKLE..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views..... <input type="checkbox"/> 73610	MANDIBLE..... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views..... <input type="checkbox"/> 70110	TMJ..... Bilateral open/closed..... <input type="checkbox"/> 70330
BONEAGE..... 1 view..... <input type="checkbox"/> 77072	MASTOIDS..... Complete min. 3 views..... <input type="checkbox"/> 70130	TOE #..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660
BONE SURVEY.. Complete..... <input type="checkbox"/> 77075	NASAL BONES.. Comp. min. 3 views..... <input type="checkbox"/> 70160	WRIST..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110
CERVICAL..... Limited 2 or 3 views..... <input type="checkbox"/> 72040 Complete w/min. 4 views..... <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views..... <input type="checkbox"/> 72052	NECK..... Soft tissue 2 views..... <input type="checkbox"/> 70360	INFANT X-RAY
CHEST..... Limited 1 view..... <input type="checkbox"/> 71045 Complete 2 views..... <input type="checkbox"/> 71046 Complete w/lardot 3 views..... <input type="checkbox"/> 71047 Complete 4 views..... <input type="checkbox"/> 71048 Special views Decubitus..... <input type="checkbox"/> 71035	ORBITS..... Complete 4 views..... <input type="checkbox"/> 70200 MRI screening..... <input type="checkbox"/> 70030	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
CLAVICLE..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000	PELVIS..... Complete 1 or 2 views..... <input type="checkbox"/> 72170	OTHER _____
ELBOW..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080	RIBS..... Unilateral 2 views..... <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views..... <input type="checkbox"/> 71110 4 views includes PA chest..... <input type="checkbox"/> 71111	
FACIAL BONES.. Complete 3 or more views..... <input type="checkbox"/> 70150		
FEMUR..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550		
FINGER(S) #..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140		
FOOT..... Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630		
FOREARM..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090		

REQUESTING PHYSICIAN:

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

FOR OFFICE USE ONLY:

TECHNICIAN Osborn Aguilar TECHNIQUE FS/4/3MAB # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/24/25 PATIENT ID # 2114 # OF CD 2/11

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

PATIENT DEMOGRAPHIC FORM 11/24/2025

KIRTADZE, MIKHEIL

DOB: 01/15/1987

Cell Phone: 646-201-1035

Sex: Male

Home phone:

DOA: 10/02/2025

Social Security Number:

Case type: No Fault

Address: 9430 LANSFORD ST, Philadelphia, PA, 19114

Primary Insurance: UNITED FINANCIAL CASUALTY COMPANY

Address: PO BOX 2930, Clinton, IA, 52733

Claim Number: 25966654868-A106029

Policy Number: 979033346-1

Policy Holder: KIRTADZE, MIKHEIL

Phone Number:

Fax:

Carrier Case:

WCB Case:

*T - ✓
sh - ✓
RN - ✓*

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: KLG - KARASIK LAW GROUP

Address: 1810 Voorhies Avenue, Suite #9, Brooklyn, NY, 11235

Phone number: 718-502-9112

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 Mikheil ("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 Mikheil Kirtanze
(Print name of Patient)

X [Signature]
(Signature of Patient)

X 11/27/2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

11/27/2025
(Date of signature)

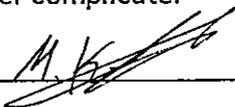
EAST STROUDSBURG PA 18301
(Address of Provider)

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: 11/24/25

Consent To X-Ray:

A Minor I am a parent or legal guardian of _____
who is a minor, _____ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this 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: KIRTADZE MIKHEIL
DATE OF BIRTH: 01/15/1987
ID/MRN: 20251124143933148
CLINICIAN: SCARBOROUGH, PAUL
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/24/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.512-PAIN IN LEFT SHOULDER

SPINE THORACIC X-RAY 2 view:

COMPARISON:

None

BONES:

No acute fracture or focal osseous lesion.

Bony alignment is anatomic.

DISCS/DEGENERATIVE CHANGES:

The disc spaces are preserved. Mild marginal osteophyte formation

SOFT TISSUES:

The adjacent soft tissues appear normal.

IMPRESSION:

No acute osseous process.

LEFT SHOULDER X-Ray Complete 2 or more views:

COMPARISON:

None

BONES:

No acute fracture or concerning focal osseous lesion.

JOINTS:

No dislocation. The joint spaces are normal.

SOFT TISSUES:

The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

LEFT KNEE X-Ray - 1-2 view:

COMPARISON:

None

BONES:

No acute fracture or concerning focal osseous lesion.

JOINTS:

No dislocation. The joint spaces are normal.

SOFT TISSUES:

The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.



DYNAMIC
MOBILE XRAY SERVICES LLC

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

Email: dynamicmobilexrays@gmail.com
website: dynamicmobilexray.com

MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/24/25

YOUR INFORMATION:

NAME Hiradze Michael D.O.B. 1/15/87 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE (____) _____
 FACILITY (IF APPLICABLE) _____ ROOM# (A) _____ ADDRESS (A) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022	HAND Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130 HEEL Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650 HIP Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520	SACRUM & COCCYX. Min. 3 views <input type="checkbox"/> 72220 SCAPULA 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010 SC JOINTS 3 views <input type="checkbox"/> 71130 SHOULDER Complete 2 views - R <input type="checkbox"/> L <input checked="" type="checkbox"/> 73030
AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050	HUMERUS Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060 KNEE Limited 1 or 2 views R <input type="checkbox"/> L <input 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	SI JOINTS Complete, 2 views <input type="checkbox"/> 72200 SINUSES Limited 2 or less <input type="checkbox"/> 70270 Complete 3+ views <input type="checkbox"/> 70220 SKULL Limited 3 views or less <input type="checkbox"/> 70250 Complete 4 views <input type="checkbox"/> 70260
ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73610	LUMBAR Limited 2 or 3 views <input type="checkbox"/> 72100 Complete 4 views w/obi <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72174 Limited w/bending 4 views <input type="checkbox"/> 72120	STERNUM Complete 2 views <input type="checkbox"/> 71120 THORACIC 2 views <input checked="" type="checkbox"/> 72072 THORACOLUMBAR. 2 views <input type="checkbox"/> 72080
BONE AGE 1 view <input type="checkbox"/> 77072 BONE SURVEY .. Complete <input type="checkbox"/> 77075	MANDIBLE Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views <input type="checkbox"/> 70110	TIBIA/FIBULA (LOWER LEG) Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590 TMJ Bilateral open/closed <input type="checkbox"/> 70330 TOE # Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660 WRIST Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110
CERVICAL Limited 2 or 3 views <input type="checkbox"/> 72040 Complete w/min. 4 views <input type="checkbox"/> 72050 Complete w/flex & ext. 7 views <input type="checkbox"/> 72052	MASTOIDS Complete min. 3 views <input type="checkbox"/> 70130 NASAL BONES .. Comp. min. 3 views <input type="checkbox"/> 70160 NECK Soft tissue 2 views <input type="checkbox"/> 70360 ORBITS Complete 4 views <input type="checkbox"/> 70200 MRI screening <input type="checkbox"/> 70030	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 _____
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	PELVIS Complete 1 or 2 views <input type="checkbox"/> 72170	
CLAVICLE Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000	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	
ELBOW Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080		
FACIAL BONES .. Complete 3 or more views <input type="checkbox"/> 70150		
FEMUR Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550		
FINGER(S) # .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140		
FOOT Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630		
FOREARM Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090		

REQUESTING PHYSICIAN:

NAME DR DAUL SCARBOROUGH NPI# _____ FAX RESULTS TO YES NO
 INDICATE REASON FOR STUDY p/o fx/parhology/pain SIGNATURE

FOR OFFICE USE ONLY:

TECHNICIAN EScarbors TECHNIQUE FS/CA/3MAB # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/24/25 PATIENT ID # 2117 # OF CD 2/11

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

PATIENT DEMOGRAPHIC FORM 11/24/2025

MEZVRISHVILI, KAKHABER

DOB: 11/06/1991

Cell Phone: 929-559-4990

Sex: Male

Home phone:

DOA: 09/19/2025

Social Security Number:

Case type: No Fault

Address: 2415 MERMAID AVE 2, Brooklyn, NY, 11224

Primary Insurance: CSAA INSURANCE

Address: PO BOX 7000, Daphne, AL, 36526

Claim Number: 1006-41-7128

Policy Number:

Policy Holder: MEZVRISHVILI, KAKHABER

Phone Number: 188-833-5272

Fax:

Carrier Case:

WCB Case:

Handwritten notes:
Sh - Left
HW - Left

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: KLG - KARASIK LAW GROUP

Address: 1810 Voorhies Avenue, Suite #9, Brooklyn, NY, 11235

Phone number: 718-502-9112

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office: 2422 Knapp St 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 Keikhaber, ("Assignor") hereby assign to DYNAMIC MOBILE XRAY SVCS., ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

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

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

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

X Keikhaber Mezvrishvili
(Print name of Patient)

X [Signature]
(Signature of Patient)

X 11.29.2025
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

11/29/25
(Date of signature)

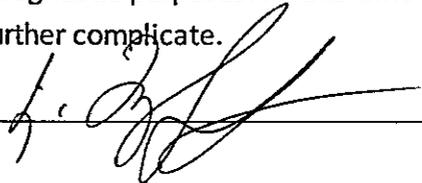
EAST STROUDSBURG PA 18301
(Address of Provider)

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: 11.24.2025

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: MEZVERISHVILLI KAKHABER

DATE OF BIRTH: 11/06/1991

ID/MRN: 20251124143300972

CLINICIAN: SCARBOROUGH, PAUL

FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC

DATE OF EXAM: 11/24/2025

HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.512-PAIN IN LEFT SHOULDER, M25.562-PAIN IN LEFT KNEE

SPINE THORACIC X-RAY 2 view:

COMPARISON:

None

BONES:

No acute fracture or focal osseous lesion.

Bony alignment is anatomic.

DISCS/DEGENERATIVE CHANGES:

The disc spaces are preserved.

SOFT TISSUES:

The adjacent soft tissues appear normal.

IMPRESSION:

No acute osseous process.

LEFT SHOULDER X-Ray Complete 2 or more views:

COMPARISON:

None

BONES:

No acute fracture or concerning focal osseous lesion.

JOINTS:

No dislocation. The joint spaces are normal.

SOFT TISSUES:

The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

LEFT KNEE X-Ray - 1-2 view:

COMPARISON:

None

BONES:

No acute fracture or concerning focal osseous lesion.

JOINTS:

No dislocation. The joint spaces are normal.

SOFT TISSUES:

The soft tissues are unremarkable.

IMPRESSION:

No acute osseous process.

Electronically Signed By: Dr. Asif Anwar M.D. 11/28/2025 11:46:32 EST

Tech: Dynamic Mobile Xray Services LLC



DYNAMIC
MOBILE XRAY SERVICES LLC

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

Email: dynamicmobilexrays@gmail.com
website: dynamicmobilexray.com

MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/24/25

YOUR INFORMATION:

NAME M. ZVERKISHVILI Karkhobek D.O.B. 11/06/91 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)

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

REQUESTING PHYSICIAN:

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

FOR OFFICE USE ONLY:

TECHNICIAN Esahon Aguelow TECHNIQUE FSR/3MAS # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/24/25 PATIENT ID # 1111 # OF CD 1/1

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

PATIENT DEMOGRAPHIC FORM 11/24/2025

BLUCHER, ARNE

DOB: 03/17/1963 Cell Phone: 917-529-6161
Sex: Male Home phone:
DOA: 09/26/2025 Social Security Number:
Case type: No Fault
Address: PO BOX 140077, Brooklyn, NY, 11214

Primary Insurance: STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY
Address: P.O BOX 2358, Bloomington, IL, 61702
Claim Number: 32-91D2-20Z
Policy Number: 199 7272-D15-32B
Policy Holder: MIKHAIL FARBER
Phone Number:
Fax:
Carrier Case:
WCB Case:

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

BI Attorney:
Address:
Phone number:
WC Attorney:
Address:
Phone number:

Referring Doctor:

Referring Office: 2422 Knapp St Chiropractic PC

*T.
L - Hip
R - Shoulder
Cats
Lumbar
Rib*

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, Anne Blucher ("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 Anne Blucher
(Print name of Patient)

X Anne Blucher
(Signature of Patient)

(Address of Patient)

X 11/24/2025
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

11/24/25
(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: *Anne Bluck* Date: 11/24/2025

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: BLUCHER ARNE
DATE OF BIRTH: 03/17/1963
ID/MRN: 20251124132859983
CLINICIAN: SCARBOROUGH, PAUL
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/24/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.561-PAIN IN RIGHT KNEE, M25.552-PAIN IN LEFT HIP

SIGNIFICANT FINDINGS

SPINE THORACIC X-RAY 2 view:

Indication: Pain in thoracic spine.

Technique: Two views thoracic spine . Single view of the chest

Comparison: None

Findings: There is suggestion of some calcification at the disc spaces within the thoracic spine. The joint space may be minimally decreased in the upper to mid thoracic spine. There are bridging osteophytes which are best seen on the frontal image. There are no acute fractures or subluxations.

The heart size is within normal limits. The lungs are clear. No pleural effusions or pneumothorax are present. There is calcification at the insertion site of the rotator cuff on the right. It may represent calcific tendinitis.

IMPRESSION:

Mild degenerative changes and possible chondrocalcinosis.

No evidence of active pulmonary disease.

LEFT Hip X-Ray unilateral 2-3 views :

Indication: Pain in left hip

Technique: Two views left hip

Comparison: None

Findings: Mild-to-moderate degenerative changes are present in the left hip. There are no acute fractures or dislocations. No intraosseous lytic or blastic lesions. There is mild osteopenia.

IMPRESSION:

Mild-to-moderate degenerative changes left hip

Electronically Signed By: Dr. Ceceleta Mailland M.D. 11/24/2025 17:49:06 EST

Tech: Dynamic Mobile Xray Services LLC



DYNAMIC
MOBILE XRAY SERVICES LLC

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

Email: dynamicmobilexrays@gmail.com
website: dynamicmobilexray.com

MOBILE PORTABLE X-RAY ORDER FORM

YOUR INFORMATION:

NAME BLUCHON Anne D.O.B. 5/17/63 SS# _____ DATE 11.24.12 MALE FEMALE

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

FACILITY (IF APPLICABLE) _____ ROOM# (A) _____ ADDRESS (A) _____ INSURANCE ID # _____

PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURES (Circle what is needed)

- ABDOMEN KUB 1 view 74000
- Complete 2 views 74020
- Acute w/ chest 3 views 74022
- AC JOINTS w/ & w/o WEIGHTS 73050
- 2 views 73050
- ANKLE Limited 2 views - R L 73040
- Complete 3 views 73610
- BONE AGE 1 view 71072
- BONE SURVEY .. Complete 77075
- CERVICAL Limited 2 or 3 views 72040
- Complete w/min. 4 views 72050
- Complete w/ flex & ext. 7 views 72052
- CHEST Limited 1 view 77045
- Complete 2 views 77046
- Complete w/ double 3 views 77047
- Complete 4 views 71048
- Special views Decubitus 71035
- CLAVICLE Complete 2 views - R L 73000
- ELBOW Complete 3 views - R L 73080
- FACIAL BONES.. Complete 3 or more views 70150
- FEMUR Complete 2 views - R L 73550
- FINGER(S) # .. Complete min. 2 views R L 73140
- FOOT Weight bearing 2 views R L 73520
- Complete 3 views - R L 73630
- FOREARM Complete 2 views - R L 73690

- HAND Complete 3 views - R L 73130
- FEET Complete 2 views - R L 73650
- HIP Complete 2 views - R L 73510
- Bilateral 2 views (each hip) - R L 73520
- FULCRUMS Complete 2 views - R L 73060
- KNEE Limited 1 or 2 views R L 73560
- Complete 3 views - R L 73562
- Complete 4 views - R L 73564
- Both knees, AP standing - R L 73565
- LUMBAR Limited 2 or 3 views 72100
- Complete 4 views w/obl. 72110
- Complete w/ bending 7 views 72114
- Limited w/ bending 4 views ... 72120
- MANDIBLE Limited 3 views - R L 70100
- Complete 4 views 70110
- MASTOIDS Complete min. 3 views 70130
- NASAL BONES.. Comp. min. 3 views 70160
- NECK Soft tissue 2 views 70360
- ORBITS Complete 4 views 70200
- ABI screening 70030
- PELVIS Complete 1 or 2 views 72170
- FIBS Unilateral 2 views 71100
- 3 views includes PA chest (trauma) 71101
- Bilateral 3 views 71110
- 4 views includes PA chest 71111
- INFANT X-RAY
- EXTREMITY Lower. 2 views 73592
- EXTREMITY Upper. 2 views 73092
- PELVIS & HIPS .. min. 2 views 73540
- WRIST Upright 2 views - R L 73100-
- OTHER _____

REQUESTING PHYSICIAN:

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

FOR OFFICE USE ONLY:

TECHNICIAN Ashton Aquilow TECHNIQUE FSK/ JAMES DATE X-RAY SENT 11.24.12 PATIENT ID # 144 # OF CD. 144
X-RAY SENT TO RADIOLOGIST YES # OF VIEWS _____

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

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

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

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

X Thomas Prezioso
(Print name of Patient)

X Thomas Prezioso
(Signature of Patient)

X 11/24/25
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

11/24/25
(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: _____

Elson Preyas

Date: _____

11/24/25

Consent To X-Ray:

A Minor I am a parent or legal guardian of _____ who is a minor, _____ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this 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

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

Email: dynamicmobilexrays@gmail.com
website: dynamicmobilexray.com

MOBILE PORTABLE X-RAY ORDER FORM

DATE 11/24/25

YOUR INFORMATION:

NAME THOMAS PREZIOSA D.O.B. 11/14/77 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (if applicable) _____ ROOM# (A) _____ ADDRESS (A) _____ 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 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/fordotc 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 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 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 PAUL SCARBOROUGH NPI# _____ FAX RESULTS TO _____
 INDICATE REASON FOR STUDY R/O fx/Pathology/pain SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN ESCARON AQUILAW TECHNIQUE 75/64/3/2/AS # OF VIEWS _____
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 11/24/25 PATIENT ID # 1111 # OF CD 1/1

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

DYNAMIC MOBILE XRAY SERVICES LLC
3412 BLUESTONE LANE
E STROUDSBURG, PA 18301
(570) 431-9721 / (570) 209-5771 FAX
dynamicmobilexrays@gmail.com
Radiology Interpretation

PATIENT NAME: PREZIOSA THOMASA
DATE OF BIRTH: 11/14/1971
ID/MRN: 20251124170605086
CLINICIAN: SCARBOROUGH, PAUL
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 11/24/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.551-PAIN IN RIGHT HIP

SIGNIFICANT FINDINGS

SPINE THORACIC X-RAY 2 view:

Osteopenia spondylosis and tilt of the thoracic column to left noted. No fracture noted.

IMPRESSION:

Osteopenia and spondylosis noted with tilt of the thoracic column to the left noted.

RIGHT Hip X-Ray unilateral 2-3 views :

There is a avulsed fracture of the acetabular lip noted. No additional fracture noted

IMPRESSION:

Acute avulsed fracture off the acetabular lip

Electronically Signed By: Steven Brownstein MD 11/28/2025 20:07:07 EST

Tech: Dynamic Mobile Xray Services LLC

This transmission is proprietary, privileged and confidential. It is intended to be communication only for the use of the addressee; access to this message by anyone else is unauthorized. If you are not the intended recipient and have received this communication in error, please notify us immediately at (570) 431-9721. Any other action taken, including but not limited to the disclosure, copying or distribution of this communication is prohibited by law.
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