

Ext

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: 12/10/25

1	SALAZAR RICHARD	26	
2	CURRY AMANDA	27	
3	Newton Starkeana	28	
4	Kelly denise e	29	
5	Tatashville Lash	30	
6	Escalante francesca	31	
7	Munez Kelly	32	
8	Griffith Mahogany	33	
9		34	
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11		36	
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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 Mahogany ("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 Mahogany Griffin
(Print name of Patient)

975 ti ferry

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301
(Address of Provider)

X M. Griffin
(Signature of Patient)

X 12/10/25
(Date of signature)

[Signature]
(Signature of Provider)

12/10/25
(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: Mahogany Guffin Date: 12/10/25

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: M. Guffin 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: GRIFFITH MAHOGANY
DATE OF BIRTH: 08/19/1991
ID/MRN: 20251210180742520
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 12/10/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE

SPINE THORACIC X-RAY 2 view:

Tilt of the thoracic column to left noted. Vertebral bodies appear of normal height. No paraspinal soft tissue mass noted. Neural foramina appear patent.

IMPRESSION:

No significant bony abnormalities noted

Electronically Signed By: Steven Brownstein MD 12/12/2025 14:31:25 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 12/10/25

YOUR INFORMATION:

NAME Griffith Mahogany D.O.B. 08/19/91 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/mln. 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 mln. 3 views <input type="checkbox"/> 70130</p> <p>NASAL BONES .. Comp. mln. 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 <u>3</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 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 FX/PAIN/PATHOLOGY SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN OSAHOW AGUEBOT TECHNIQUE ROM/SMAS # OF VIEWS N/A
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 12/10/25 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 12/10/2025

SALAZAR-BABILONIA, RICHARD

DOB: 04/02/1987

Cell Phone: 347-848-5256

Sex: Male

Home phone:

DOA: 10/24/2025

Social Security Number: 596-10-8717

Case type: No Fault

Address: 54 W 94TH STREETAPT 1B, New York, NY, 10025

Primary Insurance: PROGRESSIVE INS

Address: 725 BROADWAY, Albany, NY, 12207

Claim Number: 25-854873336

Policy Number:

Policy Holder: SALAZAR-BABILONIA, RICHARD

Phone Number:

Fax:

Carrier Case:

WCB Case:

T. - C
 C - Shoulder
 C - Hip
 C - Knee
 R - Knee
 C - Foot/Ankle

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: JOSEPH MONACO, ESQ

Address: 1818 Market St # 3200, Philadelphia, PA, 19103

Phone number: 215-546-3166

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 RICHARD SAIZARIB, ("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 10-24-25, not withstanding any other agreement
(Print accident date)
to the contrary.

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

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

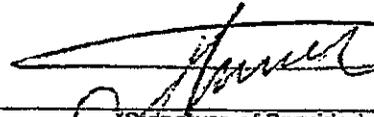
X RICHARD SAIZARIB
(Print name of Patient)

X 
(Signature of Patient)

(Address of Patient)

X 12/10/25
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)


(Signature of Provider)

3412 BLUESTONE LANE

12/10/25
(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: 12/10/25

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: _____



MOBILE PORTABLE X-RAY ORDER FORM

DATE 12/10/23

YOUR INFORMATION:

NAME SALAZAR-BASILONA RICHARD D.O.B. 04/02/87 SS# _____ MALE FEMALE

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

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

PRIMARY INSURANCE NAME _____ INSURANCE ID # _____

SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & 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 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 PTO FX / PAIN / PATHOLOGY SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN OSAHON AGUEBOR TECHNIQUE 7SEV / 5MAS # OF VIEWS N/A

X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 12/10/23 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.

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: SALAZAR-BABILONA RICHARD
DATE OF BIRTH: 04/02/1987
ID/MRN: 20251210172519768
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 12/10/2025
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

FINDINGS:

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

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

IMPRESSION:

No acute fracture or subluxation of the thoracic spine.

LEFT SHOULDER X-Ray Complete 2 or more views:

Comparison: None

FINDINGS:

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

No soft tissue swelling is seen.

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

IMPRESSION:

No acute fracture or dislocation of left shoulder.

LEFT KNEE X-Ray - 1-2 view:

Comparison: None

FINDINGS:

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

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

IMPRESSION:

No acute fracture or dislocation of the left knee.

Electronically Signed By: Dr. Lan Vu M.D. 12/12/2025 14:38:30 EST

Tech: Dynamic Mobile Xray Services LLC

EXX

PATIENT DEMOGRAPHIC FORM 12/10/2025

CURRY, AMANDA

DOB: 12/29/1984

Cell Phone: 718-450-1283

Sex: Female

Home phone:

DOA: 05/07/2025

Social Security Number: 067-76-4512

Case type: No Fault

Address: 2418 GLEBE AVE APT 1, Bronx, NY, 10461

Primary Insurance: LIBERTY MUTUAL INS

Address: PO BOX 515097, Los Angeles, CA, 90051

Claim Number: 059324944

Policy Number:

Policy Holder: CURRY, AMANDA

Phone Number:

Fax:

Carrier Case:

WCB Case:

T. Shukh

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: ALEXANDER BESPECHNY

Address: 2360 WESTCHESTER AVENUE, Bronx, NY, 10462

Phone number: 718-792-4800

WC Attorney:

Address:

Phone number:

Referring Doctor:

Referring Office:

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

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

Claim Number: _____

X Amarda Curry, ("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 5/07/2005, not withstanding any other agreement
(Print accident date)
to the contrary.

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

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

X Amarda Curry
(Print name of Patient)

X [Signature]
(Signature of Patient)

X 12/10/25
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

12/10/25
(Date of signature)

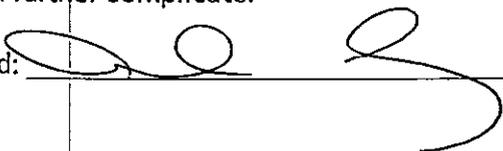
EAST STROUDSBURG PA 18301
(Address of Provider)

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: 12/10/25

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: _____



MOBILE PORTABLE X-RAY ORDER FORM

DATE 12/10/25

YOUR INFORMATION:

NAME CURRY AMANDA D.O.B. 12/29/84 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"/> 73570</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</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 FX/PAIN/PATHOLOG SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN ORATION ALBERT TECHNIQUE 95100/5MA # OF VIEWS 1/1/1
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 12/10/25 PATIENT ID # N/A # OF CD 1/1/1

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.

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: CURRY AMANDA
DATE OF BIRTH: 12/29/1984
ID/MRN: 20251210171427534
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 12/10/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.512-PAIN IN LEFT SHOULDER

SPINE THORACIC X-RAY 2 view:

Comparison: None

FINDINGS:

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

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

IMPRESSION:

No acute fracture or subluxation of the thoracic spine.

LEFT SHOULDER X-Ray Complete 2 or more views:

Comparison: None

FINDINGS:

Multiple views of the left shoulder show normal alignment at the gleno-humeral joint.
There are no acute fractures or dislocations.
The acromioclavicular joint and coracoclavicular spaces are intact.
The visualized scapula and clavicle are unremarkable.
There are no radiopaque foreign bodies.
No soft tissue swelling is seen.

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

IMPRESSION:

No acute fracture or dislocation of left shoulder.

Electronically Signed By: Dr. Lan Vu M.D. 12/12/2025 14:01:40 EST

Tech: Dynamic Mobile Xray Services LLC

Ext.

PATIENT DEMOGRAPHIC FORM 12/10/2025

NEWTON, STARKEEMA

DOB: 04/18/1989

Cell Phone: 646-464-9138

Sex: Female

Home phone:

DOA: 06/22/2025

Social Security Number: 054-76-5099

Case type: No Fault

Address: 10 RICHMAN PLAZA APT 20C, Bronx, NY, 10453

Primary Insurance: LIBERTY MUTUAL INS

Address: PO BOX 515097, Los Angeles, CA, 90051

Claim Number: 1845810

Policy Number:

Policy Holder:

Phone Number: 614-948-0343

Fax:

Carrier Case:

WCB Case:

*T
Left knee*

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 Starkeema Newton ("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 6-22-25, not withstanding any other agreement
(Print accident date)
to the contrary.

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

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

X Starkeema Newton
(Print name of Patient)

X [Signature]
(Signature of Patient)

(Address of Patient)

X 12/10/25
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

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

12/10/25
(Date of signature)

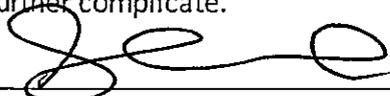
DYNAMIC MOBILE XRAY SERVICES LLC

**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: 12/10/25

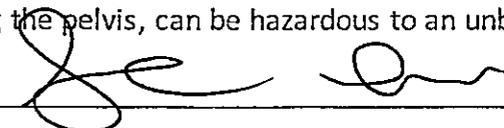
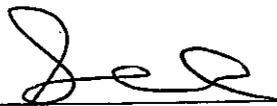
Consent To X-Ray:

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: 



MOBILE PORTABLE X-RAY ORDER FORM

DATE 12/10/25

YOUR INFORMATION:

NAME NEWTON STARKEBAUM D.O.B. 04/18/89 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<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 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 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 FX/PAIN/PATHOLOGY SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN OSAMU AGUEBOT TECHNIQUE SONY/SMAS # OF VIEWS N/A
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 12/10/25 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.

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: NEWTON STARKEEMA
DATE OF BIRTH: 04/18/1989
ID/MRN: 20251210161130980
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 12/10/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.562-PAIN IN LEFT KNEE

SPINE THORACIC X-RAY 2 view:

DORSAL SPINE: The dorsal vertebrae are in normal alignment. There is no evidence for bony erosion or destruction. There is no evidence for fracture or dislocation. Mild scoliosis convexity towards the left noted.

IMPRESSION:

Negative dorsal spine.

LEFT KNEE X-Ray - 1-2 view:

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

IMPRESSION:

No significant abnormalities noted

Electronically Signed By: Steven Brownstein MD 12/13/2025 14:35:35 EST

Tech: Dynamic Mobile Xray Services LLC

12/13/2025

ELK



PATIENT DEMOGRAPHIC FORM 12/10/2025

KELLY, DENISE.

DOB: 10/22/1997

Cell Phone: 929-754-0548

Sex: Female

Home phone:

DOA: 05/10/2025

Social Security Number:

Case type: No Fault

Address: 920 E 225TH STREET, Bronx, NY, 10466

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
Knee C/R
Shoulder R

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 Denise Kelly, ("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 Denise Kelly
(Print name of Patient)

X Denise Kelly
(Signature of Patient)

X 12/10/25
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

12/10/25
(Date of signature)

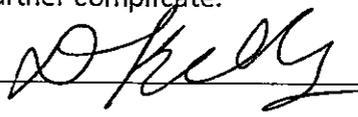
EAST STROUDSBURG PA 18301
(Address of Provider)

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

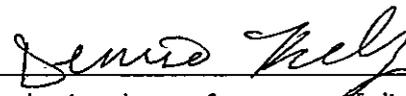
X-Ray Consent Form

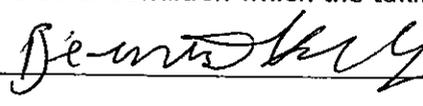
Patient Consent To X-Ray:

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: 12/10/25

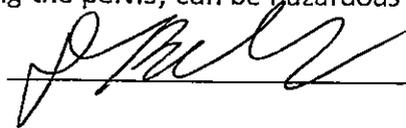
Consent To X-Ray:

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: 12/10/28

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: 12/10/25



MOBILE PORTABLE X-RAY ORDER FORM

DATE 12/10/25

YOUR INFORMATION:

NAME KELLY DENNIS E D.O.B. 10/22/97 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<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 checked="" 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 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 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 OTHER _____</p>
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REQUESTING PHYSICIAN:

NAME DR SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO _____
 INDICATE REASON FOR STUDY R/O FX/PAIN/PATHOLOGY SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN OSAYOW ABUBOT TECHNIQUE RONTG/STATS # OF VIEWS N/A
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 12/10/25 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.

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: KELLY DENISE
DATE OF BIRTH: 10/22/1997
ID/MRN: 20251210154804710
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 12/10/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER, M25.561-PAIN IN RIGHT KNEE, M79.644-PAIN IN RIGHT FINGER(S)

SPINE THORACIC X-RAY 2 view:

Indication: Pain in thoracic spine.
Technique: Two views thoracic spine
Comparison: None
Findings: Artifacts of the chest.
There is preservation of the normal thoracic kyphosis, vertebral body heights and disc spaces. No intraosseous lytic or blastic lesions are identified. The visualized lung fields are clear. The visualized ribs are unremarkable.
The visualized lumbar spine is within normal limits.

IMPRESSION:

Negative radiograph thoracic spine

RIGHT SHOULDER X-Ray Complete 2 or more views:

Indication: Pain in right shoulder.
Technique: 2 views 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 Right shoulder joint

RIGHT FINGER(S) X-Ray - 2-3 views:

Indication: Pain in right finger
Technique: Three views right hand and fingers
Comparison: None
Findings: The carpometacarpal, metacarpophalangeal and interphalangeal joints are in anatomic alignment.
The joint spaces are preserved. There is no erosive or productive arthropathy. No fracture or subluxation. No lytic or blastic bone lesions or periosteal reaction.
Periarticular soft tissues are normal.

IMPRESSION:

Negative radiographs right finger and hand

RIGHT KNEE X-Ray - 1-2 view:

Indication: Right Knee pain

Technique: Two views limited 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 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- right-knee

Electronically Signed By: Dr. Ceceleta Maitland M.D. 12/13/2025 15:03:04 EST

Tech: Dynamic Mobile Xray Services LLC

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

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

Claim Number: _____

X Lasha, ("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 Lasha Tatuashvili
(Print name of Patient)

X [Signature]
(Signature of Patient)

(Address of Patient)

X 12/10/25
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

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

12/10/25
(Date of signature)



MOBILE PORTABLE X-RAY ORDER FORM

DATE 12-10-25

YOUR INFORMATION:

NAME TATUASHNILLI CASHA D.O.B. 09/26/81 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & W/O WEIGHTS 2 views <input type="checkbox"/> 73050</p> <p>ANKLE Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views <input type="checkbox"/> 73618</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 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 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 FX/PAIN/PATHOLOGY SIGNATURE [Signature]

FOR OFFICE USE ONLY:

TECHNICIAN OSANOW AGUEBOT TECHNIQUE ROMY/SMAS # OF VIEWS N/A
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 12/10/25 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.

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: TATUASHVILLI LASHA
DATE OF BIRTH: 09/26/1981
ID/MRN: 20251210154226655
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 12/10/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.562-PAIN IN LEFT KNEE

SPINE THORACIC X-RAY 2 view:

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

IMPRESSION:

Negative dorsal spine.

LEFT KNEE X-Ray - 1-2 view:

Mild arthritic changes noted with narrowing of the medial femorotibial joint. No fracture subluxation noted.

IMPRESSION:

Mild arthritic changes noted

Electronically Signed By: Steven Brownstein MD 12/13/2025 14:38:11 EST

Printed On: 12/13/2025 14:38:11 EST

Tech: Dynamic Mobile Xray Services LLC

Ext

PATIENT DEMOGRAPHIC FORM 12/10/2025

ESCALANTE-VIVAS, FRANCISCO

DOB: 08/23/1993

Cell Phone: 347-720-2445

Sex: Male

Home phone:

DOA: 11/11/2025

Social Security Number: 145-65-4002

Case type: No Fault

Address: 175 W TREMONT AVE, Bronx, NY, 10453

Primary Insurance: GEICO

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

Claim Number: 8864895010000001

Policy Number: 6217323267

Policy Holder: ESCOBOZA, F, ANDRES

Phone Number:

Fax:

Carrier Case:

WCB Case:

T
Shed

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: STRATFORD LAW GROUP PLLC

Address: 69 STRAFORD ROAD SUITE 1B, Brooklyn, NY, 11218

Phone number: 718-715-1600

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 Francisco, ("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 Francisco Escalante
(Print name of Patient)

X Francisco Escalante
(Signature of Patient)

X 12/10/25
(Date of signature)

(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES
(Print name of Provider)

[Signature]
(Signature of Provider)

3412 BLUESTONE LANE

12/10/25
(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: Francisco Escalante Date: 12/10/25

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: _____



MOBILE PORTABLE X-RAY ORDER FORM

DATE 12/10/25

YOUR INFORMATION:

NAME ESCALANTE-VINIS Francisco D.O.B. 08/28/98 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

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

NAME DR SCARBOROUGH PAUL NPI# _____ FAX RESULTS TO _____
 INDICATE REASON FOR STUDY R/O FX/PAIN/PATHOLOGY SIGNATURE _____

FOR OFFICE USE ONLY:

TECHNICIAN OSAMU AGUIRRE TECHNIQUE SONY/SMAS # OF VIEWS N/A
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 12/10/25 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.

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: ESCALANTE-VIVAS FRANSISCO
DATE OF BIRTH: 08/23/1993
ID/MRN: 20251210151142689
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 12/10/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.512-PAIN IN LEFT SHOULDER

SIGNIFICANT FINDINGS

SPINE THORACIC X-RAY 2 view:

Indication: Pain in thoracic spine.
Technique: Two views thoracic spine
Comparison: None
Findings: The study is degraded by motion artifacts.
The study demonstrates preservation of the normal thoracic kyphosis, vertebral body heights and disc spaces. The upper thoracic spine is obscured on the lateral view. No effusions are demonstrated.

IMPRESSION:

Negative radiograph 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 study is degraded by motion artifacts.
Grossly, 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 shoulder joint.
Limited study.

Electronically Signed By: Dr. Ceceleta Maitland M.D. 12/13/2025 16:41:15 EST

Tech: Dynamic Mobile Xray Services LLC

EXT

PATIENT DEMOGRAPHIC FORM 12/10/2025

NUNEZ, RADDY

DOB: 06/05/1987

Cell Phone: 413-557-0071

Sex: Male

Home phone:

DOA: 11/03/2025

Social Security Number:

Case type: No Fault

Address: 24 METROPOLITAN OVAL MF, Bronx, NY, 10462

Primary Insurance: STATE FARM INS

Address: PO BOX 106170, Atlanta, GA, 30348

Claim Number: 32-93N9-25D

Policy Number: 3354955D0832D

Policy Holder: NUNEZ, RADDY

Phone Number:

Fax:

Carrier Case:

WCB Case:

T
R. Nunez
R. Spina

Secondary Insurance:

Address:

Claim Number:

Policy Number:

Policy Holder:

Phone Number:

Fax:

BI Attorney: STRATFORD LAW GROUP PLLC

Address: 69 STRAFORD ROAD SUITE 1B, Brooklyn, NY, 11218

Phone number: 718-715-1600

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 Raddy Nunez ("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 Raddy Nunez
(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 Raddy Nunez
(Signature of Patient)

X 12/10/25
(Date of signature)

[Signature]
(Signature of Provider)

12/10/25
(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: *Paula J. Winger* Date: 12/10/25

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: NUNEZ RADDY
DATE OF BIRTH: 06/05/1987
ID/MRN: 20251210135005067
CLINICIAN: SCARBOROUGH, PAUL. DR
FACILITY: DYNAMIC MOBILE XRAY SERVICES LLC
DATE OF EXAM: 12/10/2025
HISTORY: M54.6-PAIN IN THORACIC SPINE, M25.561-PAIN IN RIGHT KNEE, M25.511-PAIN IN RIGHT SHOULDER

SIGNIFICANT FINDINGS**SPINE THORACIC X-RAY 2 view:**

Indication: Pain in thoracic spine.
Technique: Two views thoracic spine
Comparison: None
Findings: Study is degraded by motion artifacts.
There is preservation of the normal thoracic kyphosis, vertebral body heights and disc spaces. The upper thoracic spine is obscured on the lateral view. There are no acute fractures or subluxations.

IMPRESSION:

Limited study. Grossly unremarkable examination of the thoracic spine.

RIGHT SHOULDER X-Ray Complete 2 or more views:

Indication: Pain right shoulder
Technique: 2- views right shoulder joint
Comparison: None
Findings: Study is degraded by motion artifacts.
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 shoulder joint

RIGHT KNEE X-Ray - 1-2 view:

Indication: Right Knee pain
Technique: Two views
Comparison: None
Finding: Calcification is noted adjacent to the medial femoral condyle. It may represent a calcific tendinitis or loose body.

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.

IMPRESSION:

Findings which may represent a calcific tendinitis along the medial femoral condyle. The study is otherwise negative.

Electronically Signed By: Dr. Ceceleta Maitland M.D. 12/13/2025 17:04:05 EST

Tech: Dynamic Mobile Xray Services LLC



MOBILE PORTABLE X-RAY ORDER FORM

DATE 12/10/25

YOUR INFORMATION:

NAME Nunez Raddy D.O.B. 06/05/87 SS# _____ MALE FEMALE
 ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE () _____
 FACILITY (IF APPLICABLE) _____ ROOM# (IA) _____ ADDRESS (IA) _____ CITY _____ STATE _____ ZIP _____
 PRIMARY INSURANCE NAME _____ INSURANCE ID # _____
 SECONDARY INSURANCE NAME _____ INSURANCE ID # _____

PROCEDURE: (Circle what is needed)

<p>ABDOMEN KUB 1 view <input type="checkbox"/> 74000 Complete 2 views <input type="checkbox"/> 74020 Acute w/chest 3 views <input type="checkbox"/> 74022</p> <p>AC JOINTS W/ & 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 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 9 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 R/O FX/PAIND/PATHOLOGY SIGNATURE [Signature]

FOR OFFICE USE ONLY:

TECHNICIAN OSANOW AGUEBOT TECHNIQUE ROM/STATS # OF VIEWS N/A
 X-RAY SENT TO RADIOLOGIST YES DATE X-RAY SENT 12/10/25 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.