

# J-RAY LOG SHEET

170 W. 233rd Street

## Patient Sign-In

Date: 12/15/28

Please sign-in and notify us if:  
 • New Patient • Phone/address change • Insurance Change

No.	Patient Name	Appt. Type	Appt. Date	Appt. with	New Patient	Phone/Address Change	Insurance Change
1	Rudy Luano						
2	Miguel <del>Alvarez</del>						
3	Ramon Burgos						
4	Mannel perez						
5	Carlos pens						
6	Garcia Grumely						
7	Antonio polanco						
8	John Carrasco						
9	Edison Noveg						
0	Wes DIAZ						
11	Lybett nunez						
12	Ayra Tancaver						
13	Ashley Alcantara						
14	14						
15	15						
16	16						
17	17						
18	18						
19	19						
20	20						
21	21						
22	22						
23	23						
24	24						
25	25						

### Elite Health & Wellness Center PC

- Work Area**
- Patient Info
  - Billing Info
  - Date Billing
  - Bulk Billing
  - Create New Patient
  - Documents
  - Unmailed Bills
  - Unbilled Patients
  - No Answer in 45 days
  - Missing POMs/Fax POMs
  - Verifications
  - NF-2 Not Sent Report

Open Scanner

Templates

**Quick Search**

By Last Name

By Claim #

By Patient Id

**Verifications Available**

# Request 1 Answer Left Bill

<b>Patient Info (Id: 695)</b> Show All Diary Notes		Summary Note		Fields in red required for E-submission, Brown - for WC only.			GTX ID #	
First Name	ASHLEY	Last Name	ALCANTARA	Sex: F	Height/Weight	ft	in	lbs
Address	113 WARRENT STREET	City,State,Zip	PATERSON NJ 07524	SSN/DOB:	102-0	08/26/2004		
Home Phone		Cell Phone	973-782-3277	Place Of Service	Bestcare Bronx			
Contact Info		Emer Phone		Email/CaseType	ASHLEYNICOLE@GMAIL.CO			..Select.
PntToInsurd	Self	Office	Elite Health & Wellness Center PC	WC#/Prior #				
EmplrName/Ph		Emplr Address		Emplr City,St,Zp	NJ			
Insurance Co.	GEICO Casualty Insurance; 750 Wood	Insurance Claim #	065254260000002	PT's Attorney	..Select.			
Adjuster		Adj. Phone/Fax		NoWork Frm/To				
Insurd FName	ASHLEY	Insurd LName	ALCANTARA	Sex: F	Insurd DOB	08/26/2004		
Insrd Address	113 WARRENT STREET	Insrd City,St,Zp	PATERSON NJ 07524	Policy#/MedID	09-N51933-V01			
First Visit	10/07/2025	DOA/State/Role	10/05/2025 NJ Passenger	Cntr Indication				
NF-2 Sent on	10/30/2025	Confirmed <input type="checkbox"/>	Status	OPEN	Cut Off Date:		Type: ..Select.	
Referred By	..Select.	Policy Limit	..Select.	Totals:	Billed: 0.00; Balance: 0.00; Paid: 0.00; WriteOff: 0.00			
Comments	LAWYER: DAVID A. FEINERMAN # 718-646-4800  ONE OF THE HOSPITAL RECORD IS NOT HER ITS HER BOYFRIEND NEED CORRECT INSURANCE INFORMATION TO SENT NF2 10/13/2025-AL						Diagnosis 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/> 5. <input type="text"/> 6. ..Select.	
Save Updates: AOB Already Exists. MG2 Counter MG2 Exp. Data <input type="text"/>				Missing document(s) for MAIL LOG: [Police report]				

**Tests Summary Information**

Test Date	Test Name	Comments	Provider	Delete
<input type="text"/>	..Select.		..Select.	<input type="button" value="Add"/>

**Notes Details (Showing up to 100 records)**

Records per Page: 150 Show All

Record (1.. 5) of 5

Notes Description	Notes Details	Edited By	Date Edited
Patient Info added/up dated	NFSent:10/30/2025;	Evadlm1	2025-10-30 12:23:39
Patient Info added/up dated	Note:LAWYER: DAVID A. FEINERMAN # 718-646-4800 ONE OF THE HOSPITAL RECORD IS NOT HER ITS HER BOYFRIEND NEED CORRECT INSURANCE INFORMATION TO SENT NF2 10/13/2025-AL;	Serenity	2025-10-16 10:11:20
Patient Info added/up dated	Note:LAWYER: DAVID A. FEINERMAN # 718-646-4800 ONE OF THE HOSPITAL RECORD IS NOT HER ITS HER BOYFRIEND NEED INSURED FULL NAME TO SENT NF2 10/13/2025-AL;	Kervens	2025-10-13 16:58:42
Patient Info added/up dated	Note:LAWYER: DAVID A. FEINERMAN # 718-646-4800 ONE OF THE HOSPITAL RECORD IS NOT HER ITS HER BOYFRIEND;	BestcareBronx	2025-10-13 15:21:26
Patient Info added/up dated	New Client created.	BestcareBronx	2025-10-10 16:01:29

Record (1.. 5) of 5

December							2025						
Su	Mo	Tu	We	Th	Fr	Sa	1	2	3	4	5	6	
7	8	9	10	11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30	31			

Future Appointments   
 Past Appointments

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

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

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

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

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

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

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO 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 Ashley Alcantara  
(Print name of Patient)

X Ashley Alcantara  
(Signature of Patient)

X 12/15/25  
(Date of signature)

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

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)

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

12/15/25  
(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: Ashley Arentara Date: 12-15-2025

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_  
who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this 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: Ashley Arentara Date: 12-15-2025

# DYNAMIC MOBILE XRAY SERVICES LLC

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

## Radiology Interpretation

---

**PATIENT NAME:** ASHLEY ALCANTARA  
**DATE OF BIRTH:** 08/26/2004  
**ID/MRN:** 20251215113655287  
**CLINICIAN:** DR. FIALKOV, ROSS  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 12/15/2025  
**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER

---

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

RIGHT SHOULDER: The bones and joints of the right shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

### IMPRESSION:

**Negative right shoulder.**

---

**Electronically Signed By:** Steven Brownstein MD 12/18/2025 19:36:37 EST

**Tech:** Dynamic Mobile Xray Services LLC

1 of 1 page of





**DYNAMIC**  
MOBILE XRAY SERVICES LLC

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

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

**MOBILE PORTABLE X-RAY ORDER FORM**

DATE 12/15/2009

**YOUR INFORMATION:**

NAME Ashley Allentown D.O.B. 8/26/2004 SS# \_\_\_\_\_  MALE  FEMALE  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE ( ) \_\_\_\_\_  
 FACILITY (IF APPLICABLE) \_\_\_\_\_ ROOM# (IA) \_\_\_\_\_ ADDRESS (IA) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 PRIMARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_  
 SECONDARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

**PROCEDURE: (Circle what is needed)**

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

**REQUESTING PHYSICIAN:**

NAME Ross Fialkow NPI# \_\_\_\_\_ FAX RESULTS TO ( ) \_\_\_\_\_  
 INDICATE REASON FOR STUDY R/O Ft post mva SIGNATURE [Signature]

**FOR OFFICE USE ONLY:**

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

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

**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.

### Elite Health & Wellness Center PC

- Work Area
- Patient Info
- Billing Info
- Date Billing
- Bulk Billing
- Create New Patient
- Documents
- Unmailed Bills
- Unbilled Patients
- No Answer in 45 days
- Missing POMs/Fax POMs
- Verifications
- NF-2 Not Sent Report

Open Scanner

Templates

**[Quick Search]**

By Last Name

By Claim #

By Patient Id

**Verifications Available**

#	Request	Answer	Left	Bill
New				

Patient Info (Id: 668) Show All Diary Notes		Summary Note		Fields in red required for E-submission. Brown - for WC only.			GTX ID #
First Name	AFRA	Last Name	TAVAREZ	Sex:	<input type="text" value="M"/>	Height/Weight	<input type="text" value="5' 11"/> <input type="text" value="165"/> lbs
Address	135 MARKET STREET APT 2FL	City,State,Zip	PERTH AMBOY NJ 08861	SSN/DOB:	112-5	08/05/1963	
Home Phone		Cell Phone	732-484-5034	Place Of Service	Bestcare Bronx <input type="button" value="v"/>		
Contact Info		Emer Phone		Email/CaseType	AFRATAVAREZ1963@GMAIL.COM No-Fault <input type="button" value="v"/>		
PtntToInsurd	Self <input checked="" type="checkbox"/>	Office	Elite Health & Wellness Center PC <input type="button" value="v"/>	WC#/Prior #			
EmplrName/Ph		Emplr Address		Emplr City,St,Zp	NJ <input type="button" value="v"/>		
Insurance Co.	SEDGWICK; PO BOX 14423 LEXINGT <input type="button" value="v"/>	Insurance Claim #	4A2509KPMX70001	PT's Attorney	..Select.. <input type="button" value="v"/>		
Adjuster		Adj. Phone/Fax		NoWork Frm/To			
Insurd FName	AFRA	Insurd LName	TAVAREZ	Insurd DOB	08/05/1963		
Insrd Address	135 MARKET STREET APT 2FL	Insrd City,St,Zp	PERTH AMBOY NJ 08861	Policy# /MedID	ABP6300175715		
First Visit	09/19/2025	DDA/State/Role	09/16/2025 NJ Driver <input type="button" value="v"/>	Cntr Indication			
NF-2 Sent on	<input type="checkbox"/> Confirmed <input type="checkbox"/>	Status	OPEN <input type="button" value="v"/>	Cut Off Date:	<input type="text"/>	Type:	..Select.. <input type="button" value="v"/>
Referred By	..Select.. <input type="button" value="v"/>	Policy Limit	..Select.. <input type="button" value="v"/>	Totals:	Billed: 0.00; Balance: 0.00; Paid: 0.00; WriteOff: 0.00		
Comments	AIPSO INS. / SEDGWICK PH:(212) 943-5100 REPRESENTED BY GREG GARBER. MC			Diagnosis 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/> 5. <input type="text"/> 6. ..Select.. <input type="button" value="v"/>			
[Save Updates] AOB Already Exists. MG2 Counter MG2 Exp. Dats <input type="text"/>				Missing document(s) for MAIL LOG: [Police report]			

**Tests Summary Information**

Test Date	Test Name	Comments	Provider	Delete
<input type="text"/>	..Select.. <input type="button" value="v"/>	<input type="text"/>	..Select.. <input type="button" value="v"/>	<input type="button" value="Add"/>

**Notes Details (Showing up to 100 records)**

Records per Page:

Record (1.. 7) of 7

Notes Description	Notes Details	Edited By	Date Edited
Patient Info added/updated	Note:AIPSO INS. / SEDGWICK PH:(212) 943-5100 REPRESENTED BY GREG GARBER. MC;	bestcare	2025-11-08 11:43:40
Patient Info added/updated	Insurd:1918;	Evadm1	2025-10-23 17:12:05
Client Info updated in all related offices	1918; 4A2509KPMX70001; Sep 18 2025 12:00AM; bestcare;	Evadm1	2025-10-23 17:12:05
Patient Info added/updated	ClinAddr:135 MARKET STREET APT 2FL; ClinCity:PERTH AMBOY; ClinState:NJ; ClinZip:08861; InsuredAddr:135 MARKET STREET APT 2FL; InsuredCity:PERTH AMBOY; InsuredState:NJ; InsuredZip:08861; Sex:M; InsuredSex:M;	BestcareBronx	2025-09-25 12:12:20
Patient Info added/updated	Note:AIPSO INS. / SEDGWICK PH:(212) 943-5100;	Evadm1	2025-09-19 16:37:37
Patient Info added/updated	Note:AIPSO INS. PH.;	Evadm1	2025-09-18 16:32:14
Patient Info added/updated	New Client created.	Evadm1	2025-09-19 16:31:50

Record (1.. 7) of 7

December <input type="button" value="v"/>							2025 <input type="button" value="v"/>
Su	Mo	Tu	We	Th	Fr	Sa	
	1	2	3	4	5	6	
7	8	9	10	11	12	13	
14	15	16	17	18	19	20	
21	22	23	24	25	26	27	
28	29	30	31				

Future Appointments

Past Appointments

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

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

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

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

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

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

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

X [Signature]  
(Print name of Patient)

X [Signature]  
(Signature of Patient)

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

X 12/15/25  
(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)

12/15/25  
(Date of signature)

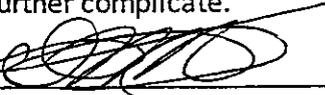
**DYNAMIC MOBILE XRAY SERVICES LLC**

**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: 12-15-25

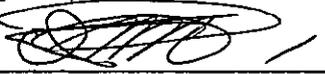
**Consent To X-Ray:**

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

Signed:  Date: 12-15-25

**Females: Regarding Possibility of Pregnancy**

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

Signed:  Date: 12-15-25

# DYNAMIC MOBILE XRAY SERVICES LLC

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

## Radiology Interpretation

---

**PATIENT NAME:** AFRA TAVAREZ  
**DATE OF BIRTH:** 08/05/1963  
**ID/MRN:** 20251215114444688  
**CLINICIAN:** DR. FIALKOV, ROSS  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 12/15/2025  
**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER

---

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

RIGHT SHOULDER: The bones and joints of the right shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

### IMPRESSION:

**Negative right shoulder.**

---

**Electronically Signed By:** Steven Brownstein MD 12/18/2025 19:36:50 EST

**Tech:** Dynamic Mobile Xray Services LLC



## MOBILE PORTABLE X-RAY ORDER FORM

DATE 12/12/23

### YOUR INFORMATION:

NAME HELEN JAVOREZ D.O.B. 8/5/63 SS# \_\_\_\_\_  MALE  FEMALE

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

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

PRIMARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

SECONDARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

### PROCEDURE: (Circle what is needed)

<p><b>ABDOMEN</b> ..... KUB 1 view ..... <input type="checkbox"/> 74000 Complete 2 views ..... <input type="checkbox"/> 74020 Acute w/chest 3 views ..... <input type="checkbox"/> 74022</p> <p><b>AC JOINTS W/ &amp; W/O WEIGHTS</b> 2 views ..... <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views ..... <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> ..... 1 view ..... <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> .. Complete ..... <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72040 Complete w/min. 4 views ..... <input type="checkbox"/> 72050 Complete w/flex &amp; ext. 7 view <input type="checkbox"/> 72052</p> <p><b>CHEST</b> ..... Limited 1 view ..... <input type="checkbox"/> 71045 Complete 2 views ..... <input type="checkbox"/> 71046 Complete w/lordotic 3 views . <input type="checkbox"/> 71047 Complete 4 views ..... <input type="checkbox"/> 71048 Special views Decubitus ..... <input type="checkbox"/> 71035</p> <p><b>CLAVICLE</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p><b>ELBOW</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b> .. Complete 3 or more views ..... <input type="checkbox"/> 70150</p> <p><b>FEMUR</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> ..... Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p><b>FOREARM</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p><b>HUMERUS</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> ..... Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p><b>LUMBAR</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72100 Complete 4 views w/obl ..... <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p><b>MANDIBLE</b> .... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views ..... <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> .... Complete min. 3 views ..... <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> .. Comp. min. 3 views ..... <input type="checkbox"/> 70160</p> <p><b>NECK</b> ..... Soft tissue 2 views ..... <input type="checkbox"/> 70360</p> <p><b>ORBITS</b> ..... Complete 4 views ..... <input type="checkbox"/> 70200 MRI screening ..... <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170</p> <p><b>RIBS</b> ..... Unilateral 2 views ..... <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views ..... <input type="checkbox"/> 71110 4 views includes PA chest ..... <input type="checkbox"/> 71111</p>	<p><b>SACRUM &amp; COCCYX</b>. Min. 3 views ..... <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> ..... 2 views - ..... R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b> ..... 3 views ..... <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b> ..... Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p><b>SI JOINTS</b> ..... Complete, 2 views ..... <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> ..... Limited 2 or less ..... <input type="checkbox"/> 70210 Complete 3+ views ..... <input type="checkbox"/> 70220</p> <p><b>SKULL</b> ..... Limited 3 views or less ..... <input type="checkbox"/> 70250 Complete 4 views ..... <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> ..... Complete 2 views ..... <input type="checkbox"/> 71120</p> <p><b>THORACIC</b> ..... 3 views ..... <input type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b>. 2 views ..... <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b> Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b> ..... Bilateral open/closed ..... <input type="checkbox"/> 70330</p> <p><b>TOE #</b> ..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b> ..... <input type="checkbox"/> 73150</p> <p><b>EXTREMITY Lower</b>. 2 views ..... <input type="checkbox"/> 73592</p> <p><b>EXTREMITY Upper</b>. 2 views ..... <input type="checkbox"/> 73092</p> <p><b>PELVIS &amp; HIPS</b> .. min. 2 views ..... <input type="checkbox"/> 73540</p> <p><b>WRIST</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p><b>OTHER</b> ..... <input type="checkbox"/> 70050</p>
--	---	---

### REQUESTING PHYSICIAN:

NAME Ross Franklin NPI# \_\_\_\_\_ FAX RESULTS TO ( ) \_\_\_\_\_

INDICATE REASON FOR STUDY R/O Fx post mva SIGNATURE [Signature]

### FOR OFFICE USE ONLY:

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_

X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT / / \_\_\_\_\_ PATIENT ID # \_\_\_\_\_ # OF CD \_\_\_\_\_

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

### Elite Health & Wellness Center PC

- Work Area**
- Patient Info**
  - Billing Info
  - Date Billing
  - Bulk Billing
  - Create New Patient
  - Documents
  - Unmailed Bills
  - Unbilled Patients
  - No Answer in 45 days
  - Missing POMs/Fax POMs
  - Verifications
  - NF-2 Not Sent Report

Open Scanner

Templates

**Quick Search**

By Last Name

By Claim #

By Patient Id

**Verifications Available**

#	Request	Answer	Left	Bill
New				

Patient Info (Id: 646) Show All Diary Notes		Summary Note		Fields in red required for E-submission, Brown - for WC only.			GTX ID #
First Name	LISBETH	Last Name	NUNEZ	Sex: F	Height/Weight	ft   in   lbs	
Address	55 EVELYN PL	City,State,Zip	BRONX NY 10468	SSN/DOB:	SSN	02/06/2001	
Home Phone		Cell Phone	646-299-3932	Place Of Service	Bestcare Bronx		
Contact Info		Emer Phone	914-258-6158	Email/CaseType	PETERNOVA08@GMAIL.COM No-Fault		
PtntToInsurd	Self	Office	Elite Health & Wellness Center PC	WC#/Prior #			
EmplrName/Ph		Emplr Address		Emplr City,St,Zp	NY		
Insurance Co.	Progressive Casualty Ins. Co; 725 BR	Insurance Claim #	25327844655	PT's Attorney	..Select..		
Adjuster		Adj. Phone/Fax		NoWork Frm/To			
Insurd FName	LISBETH	Insurd LName	NUNEZ	Sex: F	Insurd DOB	02/06/2001	
Insrd Address	55 EVELYN PL	Insrd City,St,Zp	BRONX NY 10468	Policy#/MedID	8600068775		
First Visit		DOA/State/Role	08/29/2025 NY ...	Cntr Indication			
NF-2 Sent on	<input type="text"/> Confirmed <input type="checkbox"/>	Status	OPEN	Cut Off Date:	<input type="text"/>	Type:	..Select..
Referred By	..Select..	Policy Limit	..Select..	Totals:	Billed: 0.00; Balance: 0.00; Paid: 0.00; WriteOff: 0.00		
Comments	LAYWER; STANISLAV LANDIK NUMBER; 718-362-3111 FAX #; 347-521-2085 GMAIL; LADNIKLAW@GMAIL.COM			Diagnosis	1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/> 5. <input type="text"/> 6. ..Select..		
Save Updates	AOB Already Exlsts. MG2 Counter		MG2 Exp. Date	Missing document(s) for MAIL LOG: [Police report]			

**Tests Summary Information**

Test Date	Test Name	Comments	Provider	Delete
<input type="text"/>	..Select..		..Select..	<input type="button" value="Add"/>

**Notes Details (Showing up to 100 records)**

Records per Page: 150

Record (1.. 3) of 3

Notes Description	Notes Details	Edited By	Data Edited
Patient Info added/updated	Sex:F; InsuredSex:F;	BestcareBronx	2025-09-16 11:44:50
Patient Info added/updated	Nota:LAYWER; STANISLAV LANDIK NUMBER; 718-362-3111 FAX #; 347-521-2085 GMAIL; LADNIKLAW@GMAIL.COM;	BestcareBronx	2025-09-11 11:31:34
Patient Info added/updated	New Client created.	BestcareBronx	2025-09-02 15:02:38

Record (1.. 3) of 3

December 2025						
Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Future Appointments   
 Past Appointments

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

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

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

X I, Libeth 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 08/29/2025, not withstanding any other agreement  
(Print accident date)  
to the contrary.

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

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

X Libeth nunez  
(Print name of Patient)

X Libeth nunez  
(Signature of Patient)

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

X 12/15/25  
(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)

12/15/25  
(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: Joseph [Signature] Date: 12/15/2025

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_  
who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this 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:** LISBETH NUNEZ  
**DATE OF BIRTH:** 02/06/2001  
**ID/MRN:** 20251215115236410  
**CLINICIAN:** DR. FIALKOV, ROSS  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 12/15/2025  
**HISTORY:** M25.512-PAIN IN LEFT SHOULDER

---

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

**LEFT SHOULDER:** The bones and joints of the left shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

**IMPRESSION:**

**Negative left shoulder.**

---

**Electronically Signed By:** Steven Brownstein MD 12/18/2025 19:37:48 EST

**Tech:** Dynamic Mobile Xray Services LLC



**DYNAMIC**  
MOBILE XRAY SERVICES LLC

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

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

**MOBILE PORTABLE X-RAY ORDER FORM**

DATE 12-7-07

**YOUR INFORMATION:**

NAME Lisbeth Nunez D.O.B. 2/6/01 SS# \_\_\_\_\_  MALE  FEMALE  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE ( ) \_\_\_\_\_  
 FACILITY (IF APPLICABLE) \_\_\_\_\_ ROOM# (IA) \_\_\_\_\_ ADDRESS (IA) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 PRIMARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_  
 SECONDARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

**PROCEDURE: (Circle what is needed)**

<p><b>ABDOMEN</b> . . . . . KUB 1 view . . . . . <input type="checkbox"/> 74000          Complete 2 views . . . . . <input type="checkbox"/> 74020          Acute w/chest 3 views . . . . . <input type="checkbox"/> 74022</p> <p><b>AC JOINTS W/ &amp; W/O WEIGHTS</b>          2 views . . . . . <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> . . . . . Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600          Complete 3 views . . . . . <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> . . . . . 1 view . . . . . <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> . . . . . Complete . . . . . <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> . . . . . Limited 2 or 3 views . . . . . <input type="checkbox"/> 72040          Complete w/min. 4 views . . . . . <input type="checkbox"/> 72050          Complete w/flex &amp; ext. 7 view <input type="checkbox"/> 72052</p> <p><b>CHEST</b> . . . . . Limited 1 view . . . . . <input type="checkbox"/> 71045          Complete 2 views . . . . . <input type="checkbox"/> 71046          Complete w/lordotic 3 views . . . . . <input type="checkbox"/> 71047          Complete 4 views . . . . . <input type="checkbox"/> 71048          Special views Decubitus . . . . . <input type="checkbox"/> 71035</p> <p><b>CLAVICLE</b> . . . . . Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p><b>ELBOW</b> . . . . . Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b> . . . . . Complete 3 or more views . . . . . <input type="checkbox"/> 70150</p> <p><b>FEMUR</b> . . . . . Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> . . . . . Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> . . . . . Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620          Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p><b>FOREARM</b> . . . . . Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b> . . . . . Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b> . . . . . Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> . . . . . Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510          Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p><b>HUMERUS</b> . . . . . Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> . . . . . Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560          Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562          Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564          Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p><b>LUMBAR</b> . . . . . Limited 2 or 3 views . . . . . <input type="checkbox"/> 72100          Complete 4 views w/obl . . . . . <input type="checkbox"/> 72110          Complete w/bending 7 views <input type="checkbox"/> 72114          Limited w/bending 4 views . . . . . <input type="checkbox"/> 72120</p> <p><b>MANDIBLE</b> . . . . . Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100          Complete 4 views . . . . . <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> . . . . . Complete min. 3 views . . . . . <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> . . . . . Comp. min. 3 views . . . . . <input type="checkbox"/> 70160</p> <p><b>NECK</b> . . . . . Soft tissue 2 views . . . . . <input type="checkbox"/> 70360</p> <p><b>ORBITS</b> . . . . . Complete 4 views . . . . . <input type="checkbox"/> 70200          MRI screening . . . . . <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> . . . . . Complete 1 or 2 views . . . . . <input type="checkbox"/> 72170</p> <p><b>RIBS</b> . . . . . Unilateral 2 views . . . . . <input type="checkbox"/> 71100          3 views includes PA chest (trauma) <input type="checkbox"/> 71101          Bilateral, 3 views . . . . . <input type="checkbox"/> 71110          4 views includes PA chest . . . . . <input type="checkbox"/> 71111</p>	<p><b>SACRUM &amp; COCCYX</b> . . . . . Min. 3 views . . . . . <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> . . . . . 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b> . . . . . 3 views . . . . . <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b> . . . . . Complete, 2 views - R <input type="checkbox"/> L <input checked="" type="checkbox"/> 73030</p> <p><b>SI JOINTS</b> . . . . . Complete, 2 views . . . . . <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> . . . . . Limited 2 or less . . . . . <input type="checkbox"/> 70210          Complete 3+ views . . . . . <input type="checkbox"/> 70220</p> <p><b>SKULL</b> . . . . . Limited 3 views or less . . . . . <input type="checkbox"/> 70250          Complete 4 views . . . . . <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> . . . . . Complete 2 views . . . . . <input type="checkbox"/> 71120</p> <p><b>THORACIC</b> . . . . . 3 views . . . . . <input type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b> . . . . . 2 views . . . . . <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b>          Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b> . . . . . Bilateral open/closed . . . . . <input type="checkbox"/> 70330</p> <p><b>TOE #</b> . . . . . Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> . . . . . Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110          . . . . . R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b>          . . . . . <input type="checkbox"/> 71110</p> <p><b>EXTREMITY Lower</b> . . . . . 2 views . . . . . <input type="checkbox"/> 73592</p> <p><b>EXTREMITY Upper</b> . . . . . 2 views . . . . . <input type="checkbox"/> 73092</p> <p><b>PELVIS &amp; HIPS</b> . . . . . min. 2 views . . . . . <input type="checkbox"/> 73540</p> <p><b>WRIST</b> . . . . . Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100          . . . . . or less . . . . . <input type="checkbox"/> 73100</p> <p><b>OTHER</b> . . . . . <input type="checkbox"/> 71065</p>
--	---	---

**REQUESTING PHYSICIAN:**

NAME Ross Fowler NPI# \_\_\_\_\_ FAX RESULTS TO ( ) \_\_\_\_\_  
 INDICATE REASON FOR STUDY R/O Ft post MVA SIGNATURE [Signature]

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_  
 X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT / / \_\_\_\_\_ PATIENT ID # \_\_\_\_\_ # OF CD \_\_\_\_\_

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

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

### Elite Health & Wellness Center PC

**Work Area**

- Patient Info
- Billing Info
- Date Billing
- Bulk Billing
- Create New Patient
- Documents
- Unmailed Bills
- Unbilled Patients
- No Answer In 45 days
- Missing POMs/Fax POMs
- Verifications
- NF-2 Not Sent Report

**Open Scanner**

---

**Templates**

..Select..

**[Quick Search]**

By Last Name

By Claim #

By Patient Id

**Verifications Available**

# | Request | Answer | Left | Bill

New

<b>Patient Info (Id: 647)</b>		<b>Show All Diary Notes</b>		<b>Summary Note</b>		<b>Fields in red required for E-submission, Brown - for WC only.</b>			<b>GTX ID #</b>	
<b>First Name</b>	LUIS OLIVER	<b>Last Name</b>	CARRASCO DIAZ	<b>Sex:</b>	M	<b>Height/Weight</b>	ft	in	lbs	
<b>Address</b>	55 EVELYN PL	<b>City,State,Zip</b>	BRONX NY 10468	<b>SSN/DOB:</b>	SSN	09/05/1995				
<b>Home Phone</b>		<b>Cell Phone</b>	413-240-8863	<b>Place Of Service</b>	Bestcare Bronx					
<b>Contact Info</b>		<b>Emer Phone</b>		<b>Email/CaseType</b>	luisolvercarrasco@gmail.com   ..Select.					
<b>PnttToInsurd</b>	Self	<b>Office</b>	Elite Health & Wellness Center PC	<b>WC#/Prior #</b>						
<b>EmplrName/Ph</b>		<b>Emplr Address</b>		<b>Emplr City,St,Zp</b>	NY					
<b>Insurance Co.</b>	Progressive Casualty Ins. Co; 725 BR	<b>Insurance Claim #</b>	25327844655	<b>PT's Attorney</b>	..Select.					
<b>Adjuster</b>		<b>Adj. Phone/Fax</b>		<b>NoWork Frm/To</b>						
<b>Insurd FName</b>	LUIS OLIVER	<b>Insurd LName</b>	CARRASCO DIAZ	<b>Sex:</b>	M	<b>Insurd DOB</b>	09/05/1995			
<b>Insrd Address</b>	55 EVELYN PL	<b>Insrd City,St,Zp</b>	BRONX NY 10468	<b>Policy#/MedID</b>	B600068775					
<b>First Visit</b>		<b>DOA/State/Role</b>	08/29/2025 NY	<b>Cntr Indication</b>						
<b>NF-2 Sent on</b>	<input type="text"/>	<b>Confirmed</b>	<input type="checkbox"/>	<b>Status</b>	OPEN		<b>Cut Off Date:</b>	<input type="text"/>	<b>Type:</b>	..Select.
<b>Referred By</b>	..Select.		<b>Policy Limit</b>	..Select.		<b>Totals:</b>	Billed: 0.00; Balance: 0.00; Paid: 0.00; WriteOff: 0.00			
<b>Comments</b>	LAWYER; STANISLAV LANDIK NUMBER; 718-362-3111 FAX #; 347-521-2085 GMAIL; LADNIKLAW@GMAIL.COM						<b>Diagnosis</b> 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/> 5. <input type="text"/> 6. ..Select.			
<b>Save Updates:</b>	AOB Already Exsts. <input type="checkbox"/>		<b>MG2 Counter</b>	<input type="text"/>	<b>MG2 Exp. Date</b>	<input type="text"/>	<b>Missing document(s) for MAIL LOG: [Police report]</b>			

**Tests Summary Information**

Test Date	Test Name	Comments	Provider	Delete
<input type="text"/>	..Select.	<input type="text"/>	..Select.	<input type="button" value="Add"/>

**Notes Details (Showing up to 100 records)**

Records per Page: 150

Record (1.. 7) of 7

Notes Description	Notes Details	Edited By	Date Edited
Patient Info added/updated	CliniCell:413-240-8863;	Evadm1	2025-12-08 17:10:58
Patient Info added/updated	Email:luisolvercarrasco@gmail.com;	BestcareBronx	2025-09-30 14:05:19
Patient Info added/updated	Note:LAWYER; STANISLAV LANDIK NUMBER; 718-362-3111 FAX #; 347-521-2085 GMAIL; LADNIKLAW@GMAIL.COM;	BestcareBronx	2025-09-11 11:31:09
Patient Info added/updated	Note:STANISLAV LADNIK, P.C 718-362-3111;	Evadm1	2025-09-08 12:09:37
Patient Info added/updated	InsurId:627;	Evadm1	2025-09-02 16:34:28
Client Info updated in all related offices	627; 25327844655; Aug 29 2025 12:00AM; bestcare;	Evadm1	2025-09-02 15:34:28
Patient Info added/updated	New Client created.	BestcareBronx	2025-09-02 16:22:01

Record (1.. 7) of 7

December 2025

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Future Appointments

Past Appointments

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

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

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

X I, Ju's Carrasco, ("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 Ju's Oliver Carrasco Diaz  
(Print name of Patient)

X Ju's Oliver Carrasco D.  
(Signature of Patient)

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

X 12/15/25  
(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)

12/15/25  
(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: Frank Oliver Caterino D. Date: 12/15/25

**Consent To X-Ray:**

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

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

**Females: Regarding Possibility of Pregnancy**

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

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

# DYNAMIC MOBILE XRAY SERVICES LLC

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

## Radiology Interpretation

**PATIENT NAME:** LUIS OLIVER CARASCO DIAZ  
**DATE OF BIRTH:** 09/05/1995  
**ID/MRN:** 20251215120239503  
**CLINICIAN:** DR. FIALKOV, ROSS  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 12/15/2025  
**HISTORY:** M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER

### SPINE THORACIC X-RAY 2 view:

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

### IMPRESSION:

Tilt of the thoracic column to left noted. No fracture noted.

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

RIGHT SHOULDER: The bones and joints of the right shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

### IMPRESSION:

Negative right shoulder.

**Electronically Signed By:** Steven Brownstein MD 12/18/2025 19:39:23 EST

**Tech:** Dynamic Mobile Xray Services LLC



**DYNAMIC**  
MOBILE XRAY SERVICES LLC

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

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

**MOBILE PORTABLE X-RAY ORDER FORM**

DATE 12/20/25

**YOUR INFORMATION:**

NAME Luis Oliver Diaz D.O.B. 9/5/95 SS# \_\_\_\_\_  MALE  FEMALE

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

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

PRIMARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

SECONDARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

**PROCEDURE: (Circle what is needed)**

<p><b>ABDOMEN</b> ..... KUB 1 view ..... <input type="checkbox"/> 74000 Complete 2 views ..... <input type="checkbox"/> 74020 Acute w/chest 3 views ..... <input type="checkbox"/> 74022</p> <p><b>AC JOINTS W/ &amp; W/O WEIGHTS</b> 2 views ..... <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views ..... <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> ..... 1 view ..... <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> .. Complete ..... <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72040 Complete w/min. 4 views ..... <input type="checkbox"/> 72050 Complete w/flex &amp; ext. 7 view <input type="checkbox"/> 72052</p> <p><b>CHEST</b> ..... Limited 1 view ..... <input type="checkbox"/> 71045 Complete 2 views ..... <input type="checkbox"/> 71046 Complete w/lordotic 3 views ..... <input type="checkbox"/> 71047 Complete 4 views ..... <input type="checkbox"/> 71048 Special views Decubitus ..... <input type="checkbox"/> 71035</p> <p><b>CLAVICLE</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p><b>ELBOW</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b> .. Complete 3 or more views ..... <input type="checkbox"/> 70150</p> <p><b>FEMUR</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> ..... Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p><b>FOREARM</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p><b>HUMERUS</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> ..... Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p><b>LUMBAR</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72100 Complete 4 views w/obl ..... <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p><b>MANDIBLE</b> .... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views ..... <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> .... Complete min. 3 views ..... <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> .. Comp. min. 3 views ..... <input type="checkbox"/> 70160</p> <p><b>NECK</b> ..... Soft tissue 2 views ..... <input type="checkbox"/> 70360</p> <p><b>ORBITS</b> ..... Complete 4 views ..... <input type="checkbox"/> 70200 MRI screening ..... <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170</p> <p><b>RIBS</b> ..... Unilateral 2 views ..... <input type="checkbox"/> 71100 3 views Includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views ..... <input type="checkbox"/> 71110 4 views includes PA chest ..... <input type="checkbox"/> 71111</p>	<p><b>SACRUM &amp; COCCYX</b>. Min. 3 views ..... <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> ..... 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b> ..... 3 views ..... <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b> .... Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p><b>SI JOINTS</b> ..... Complete, 2 views ..... <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> ..... Limited 2 or less ..... <input type="checkbox"/> 70210 Complete 3+ views ..... <input type="checkbox"/> 70220</p> <p><b>SKULL</b> ..... Limited 3 views or less ..... <input type="checkbox"/> 70250 Complete 4 views ..... <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> ..... Complete 2 views ..... <input type="checkbox"/> 71120</p> <p><b>THORACIC</b> ..... 2 views ..... <input checked="" type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b>. 2 views ..... <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b> Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b> ..... Bilateral open/closed ..... <input type="checkbox"/> 70330</p> <p><b>TOE #</b> ..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b> EXTREMITY Lower. 2 views ..... <input type="checkbox"/> 73592 EXTREMITY Upper. 2 views ..... <input type="checkbox"/> 73092 PELVIS &amp; HIPS .. min. 2 views ..... <input type="checkbox"/> 73540 WRIST ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100 OTHER _____ <input type="checkbox"/> 70000</p>
--	---	--

**REQUESTING PHYSICIAN:**

NAME Ross Fowler NPI# \_\_\_\_\_ FAX RESULTS TO ( ) \_\_\_\_\_

INDICATE REASON FOR STUDY R/O Ft post mva SIGNATURE [Signature]

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_

X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT / / \_\_\_\_\_ PATIENT ID # \_\_\_\_\_ # OF CD \_\_\_\_\_

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

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

### Elite Health & Wellness Center PC

- Work Area
- Patient Info
- Billing Info
- Date Billing
- Bulk Billing
- Create New Patient
- Documents
- Unmailed Bills
- Unbilled Patients
- No Answer in 45 days
- Missing POMs/Fax POMs
- Verifications
- NF-2 Not Sent Report

Open Scanner

Templates

**[Quick Search]**

By Last Name

By Claim #

By Patient Id

**Verifications Available**

# | Request | Answer | Left | Bill

New

Patient Info (Id: 679) Show All Diary Notes		Summary Note		Fields in red required for E-submission. Brown - for WC only.			GTX ID #
First Name	EDDISON JOSE	Last Name	NOVA CABRERA	Sex:	<input type="text" value="M"/>	Height/Weight	ft   in   lbs
Address	347 EAST 173 STREET APT 3B	City,State,Zip	BRONX NY 10457	SSN/DOB:	033-8	02/01/1994	
Home Phone		Cell Phone	413-309-3432	Place Of Service	Bestcare Bronx <input type="button" value="v"/>		
Contact Info		Emer Phone		Email/CaseType	<input type="text"/> No-Fault <input type="button" value="v"/>		
PtnToInsurd	Self <input type="button" value="v"/>	Office	Elite Health & Wellness Center PC <input type="button" value="v"/>	WC#/Prior #			
EmplrName/Ph		Emplr Address		Emplr City,St,Zp	NY <input type="button" value="v"/>		
Insurance Co.	SEE MTX; Unknown , NY <input type="button" value="v"/>	Insurance Claim #	85-00851681	PT's Attorney	..Select.. <input type="button" value="v"/>		
Adjuster		Adj. Phone/Fax		NoWork Frm/To			
Insurd FName	EDDISON JOSE	Insurd LName	NOVA CABRERA	Sex:	<input type="text" value="M"/>	Insurd DOB	02/01/1994
Insrd Address	347 EAST 173 STREET APT 3B	Insrd City,St,Zp	BRONX NY 10457	Policy#/MedID	ANN-MO75247		
First Visit		DOA/State/Role	09/26/2025 NY Passenger <input type="button" value="v"/>	Cntr Indcation			
NF-2 Sent on	<input type="text"/> Confirmed <input type="checkbox"/>	Status	OPEN <input type="button" value="v"/>	Cut Off Date:	<input type="text"/>	Type:	..Select.. <input type="button" value="v"/>
Referred By	..Select.. <input type="button" value="v"/>	Policy Limit	..Select.. <input type="button" value="v"/>	Totals:	Billed: 0.00; Balance: 0.00; Paid: 0.00; WriteOff: 0.00		
Comments	INSURANCES INF: THE HANOVER INSURANCE GROUP AGENCY, INC 440 LINCOLN ST, WORCESTER, MA 01653 # 800-922-8427			Diagnosis 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/> 5. <input type="text"/> 6. ..Select.. <input type="button" value="v"/>			
<input type="button" value="Save Updates"/> AOB Already Exlsts. MG2 Counter <input type="text"/> MG2 Exp. Date <input type="text"/>				Missing document(s) for MAIL LOG: [Police report]			

**Tests Summary Information**

Test Date	Test Name	Comments	Provider	Delete
<input type="text"/>	..Select.. <input type="button" value="v"/>	<input type="text"/>	..Select.. <input type="button" value="v"/>	<input type="button" value="Add"/>

**Notes Details (Showing up to 100 records)**

Records per Page : 150

Record (1.. 6) of 6

Notes Description	Notes Details	Edited By	Date Edited
Patient Info added/updated	CntCell:413-309-3432;	BestcareBronx	2025-11-12 11:03:07
Patient Info added/updated	InsClaim:85-00851681;	BestcareBronx	2025-11-10 12:50:20
Client Info updated in all related offices	508; 85-00851681; Sep 26 2025 12:00AM; bestcare;	BestcareBronx	2025-11-10 12:50:20
Patient Info added/updated	Note:INSURANCES INF: THE HANOVER INSURANCE GROUP AGENCY, INC 440 LINCOLN ST, WORCESTER, MA 01653 # 800-922-8427;	BestcareBronx	2025-10-17 12:19:18
Patient Info added/updated	Note:INSURANCES INF: A-AFFORDABLE INSURANCE AGENCY, INC 1237 WORCESTER ROAD, FRANINGHAM, MA 017001 # 800-897-2837;	Evadm1	2025-10-09 14:34:53
Patient Info added/updated	New Client created.	BestcareBronx	2025-09-29 13:22:08

Record (1.. 6) of 6

December <input type="button" value="v"/>							2025 <input type="button" value="v"/>
Su	Mo	Tu	We	Th	Fr	Sa	
	1	2	3	4	5	6	
7	8	9	10	11	12	13	
14	15	16	17	18	19	20	
21	22	23	24	25	26	27	
28	29	30	31				

Futura Appointments

Past Appointments

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

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

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

X EDDISON JOSE, ("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 EDDISON JOSE  
(Print name of Patient)

X EDDISON JOSE  
(Signature of Patient)

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

X 12/15/25  
(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)

12/15/25  
(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: \_\_\_\_\_

**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:** EDISON NOVA  
**DATE OF BIRTH:** 02/01/1994  
**ID/MRN:** 20251215121414278  
**CLINICIAN:** DR. FIALKOV, ROSS  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 12/15/2025  
**HISTORY:** M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER

### 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.

### IMPRESSION:

**Negative dorsal spine.**

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

**RIGHT SHOULDER:** The bones and joints of the right shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

### IMPRESSION:

**Negative right shoulder.**

**Electronically Signed By:** Steven Brownstein MD 12/18/2025 19:42:32 EST

**Tech:** Dynamic Mobile Xray Services LLC



**MOBILE PORTABLE X-RAY ORDER FORM**

DATE 12/10/25

**YOUR INFORMATION:**

NAME Edison Noug D.O.B. 2-11-94 SS# \_\_\_\_\_  MALE  FEMALE  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE ( ) \_\_\_\_\_  
 FACILITY (IF APPLICABLE) \_\_\_\_\_ ROOM# (IA) \_\_\_\_\_ ADDRESS (IA) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 PRIMARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_  
 SECONDARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

**PROCEDURE: (Circle what is needed)**

<p><b>ABDOMEN</b> ..... KUB 1 view ..... <input type="checkbox"/> 74000          Complete 2 views ..... <input type="checkbox"/> 74020          Acute w/chest 3 views ..... <input type="checkbox"/> 74022</p> <p><b>AC JOINTS W/ &amp; W/O WEIGHTS</b>          2 views ..... <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600          Complete 3 views ..... <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> ..... 1 view ..... <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> .. Complete ..... <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72040          Complete w/min. 4 views ..... <input type="checkbox"/> 72050          Complete w/flex &amp; ext. 7 views ..... <input type="checkbox"/> 72052</p> <p><b>CHEST</b> ..... Limited 1 view ..... <input type="checkbox"/> 71045          Complete 2 views ..... <input type="checkbox"/> 71046          Complete w/ordotic 3 views ..... <input type="checkbox"/> 71047          Complete 4 views ..... <input type="checkbox"/> 71048          Special views Decubitus ..... <input type="checkbox"/> 71035</p> <p><b>CLAVICLE</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p><b>ELBOW</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b> .. Complete 3 or more views ..... <input type="checkbox"/> 70150</p> <p><b>FEMUR</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> ..... Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620          Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p><b>FORBARM</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510          Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p><b>HUMERUS</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> ..... Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560          Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562          Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564          Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p><b>LUMBAR</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72100          Complete 4 views w/obl ..... <input type="checkbox"/> 72110          Complete w/bending 7 views ..... <input type="checkbox"/> 72114          Limited w/bending 4 views ..... <input type="checkbox"/> 72120</p> <p><b>MANDIBLE</b> .... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100          Complete 4 views ..... <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> .... Complete min. 3 views ..... <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> .. Comp. min. 3 views ..... <input type="checkbox"/> 70160</p> <p><b>NECK</b> ..... Soft tissue 2 views ..... <input type="checkbox"/> 70360</p> <p><b>ORBITS</b> ..... Complete 4 views ..... <input type="checkbox"/> 70200          MRI screening ..... <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170</p> <p><b>RIBS</b> ..... Unilateral 2 views ..... <input type="checkbox"/> 71100          3 views includes PA chest (trauma) ..... <input type="checkbox"/> 71101          Bilateral, 3 views ..... <input type="checkbox"/> 71110          4 views includes PA chest ..... <input type="checkbox"/> 71111</p>	<p><b>SACRUM &amp; COCCYX</b>. Min. 3 views ..... <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> ..... 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b> ..... 3 views ..... <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b> ..... Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p><b>SI JOINTS</b> ..... Complete, 2 views ..... <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> ..... Limited 2 or less ..... <input type="checkbox"/> 70210          Complete 3+ views ..... <input type="checkbox"/> 70220</p> <p><b>SKULL</b> ..... Limited 3 views or less ..... <input type="checkbox"/> 70250          Complete 4 views ..... <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> ..... Complete 2 views ..... <input type="checkbox"/> 71120</p> <p><b>THORACIC</b> ..... 2 views ..... <input checked="" type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b>. 2 views ..... <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b>          Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b> ..... Bilateral open/closed ..... <input type="checkbox"/> 70330</p> <p><b>TOE #</b> ..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b></p> <p><b>EXTREMITY Lower</b>. 2 views ..... <input type="checkbox"/> 73592</p> <p><b>EXTREMITY Upper</b>. 2 views ..... <input type="checkbox"/> 73092</p> <p><b>PELVIS &amp; HIPS</b> .. min. 2 views ..... <input type="checkbox"/> 73540</p> <p><b>WRIST</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p><b>OTHER</b> ..... <input type="checkbox"/> 70000</p>
---	--	--

**REQUESTING PHYSICIAN:**

NAME Ross F. Ivankov NPI# \_\_\_\_\_ FAX RESULTS TO ( ) \_\_\_\_\_  
 INDICATE REASON FOR STUDY R/O Ft post mva SIGNATURE [Signature]

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_  
 X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT \_\_\_\_/\_\_\_\_/\_\_\_\_ PATIENT ID # \_\_\_\_\_ # OF CD \_\_\_\_\_

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

### Elite Health & Wellness Center PC

- Work Area** ✖
- Patient Info
  - Billing Info
  - Date Billing
  - Bulk Billing
  - Create New Patient
  - Documents
  - Unmailed Bills
  - Unbilled Patients
  - No Answer in 45 days
  - Missing POMs/Fax POMs
  - Verifications
  - NF-2 Not Sent Report

Open Scanner

Templates

**[Quick Search]**

By Last Name

By Claim #

By Patient Id

**Verifications Available**

# | Request | Answer | Left | Bill  
 New

<b>Patient Info (Id: 652)</b>		<b>Show All Diary Notes</b>		<b>Summary Note</b>		<b>Fields in red required for E-submission, Brown - for WC only.</b>			<b>GTX ID #</b>	
<b>First Name</b>	RUDDY ANTONIO	<b>Last Name</b>	LIRIANO BRITO	<b>Sex:</b>	M	<b>Height/Weight</b>	ft	in	lbs	
<b>Address</b>	370 FORT WASHINGTON AVE	<b>City,State,Zip</b>	MANHATTAN NY 10033	<b>SSN/DOB:</b>	208-78-8978	12/31/1984				
<b>Home Phone</b>		<b>Cell Phone</b>	978-437-3835	<b>Place Of Service</b>	Bestcare Bronx					
<b>Contact Info</b>		<b>Emer Phone</b>	978-397-2611	<b>Email/CaseType</b>	RUDDYBRITO31@GMAIL.CO No-Fault					
<b>PtnkToInsurd</b>	Self	<b>Office</b>	Elite Health & Wellness Center PC	<b>WC#/Prior #</b>						
<b>EmplrName/Ph</b>		<b>Emplr Address</b>		<b>Emplr City,St,Zp</b>	NY					
<b>Insurance Co.</b>	Progressive Casualty Ins. Co; 725 BR	<b>Insurance Claim #</b>	25806947728	<b>PT's Attorney</b>	..Select..					
<b>Adjuster</b>	BRIAN FLEMING	<b>Adj. Phone/Fax</b>	678-728-6911	<b>NoWork Frm/To</b>						
<b>Insurd FName</b>	RUDDY ANTONIO	<b>Insurd LName</b>	LIRIANO BRITO	<b>Insurd DOB</b>	12/31/1984					
<b>Insrd Address</b>	370 FORT WASHINGTON AVE	<b>Insrd City,St,Zp</b>	MANHATTAN NY 10033	<b>Policy#/MedID</b>	996887423					
<b>First Visit</b>		<b>DOA/State/Role</b>	09/08/2025 NY Driver	<b>Cntr Indication</b>						
<b>NF-2 Sent on</b>		<b>Confirmed</b>	<input type="checkbox"/>	<b>Status</b>	OPEN		<b>Cut Off Date:</b>		<b>Type:</b>	..Select..
<b>Referred By</b>	..Select..	<b>Policy Limit</b>	..Select..	<b>Totals:</b>	Billed: 0.00; Balance: 0.00; Paid: 0.00; WriteOff: 0.00					
<b>Comments</b>	LAWYER KELVIN CALDWELL Eppinger Reingold&Korder 131 Larchmont Ave, Larchmont, NY 10538 (914) 833-0500						<b>Diagnosis</b> 1. 2. 3. 4. 5. 6. ..Select..			
<b>Save Updates:</b> AOB Already Exists. MG2 Counter: MG2 Exp. Date: <input type="text"/>				<b>Missing document(s) for MAIL LOG: [Police report]</b>						

**Tests Summary Information**

Test Date	Test Name	Comments	Provider	Delete
<input type="text"/>	..Select..		..Select..	<input type="button" value="Add"/>

**Notes Details (Showing up to 100 records)**

Records per Page: 150

Record (1.. 3) of 3

Notes Description	Notes Details	Edited By	Date Edited
Patient Info added/updated	FName:RUDDY ANTONIO; InsuredFName:RUDDY ANTONIO;	Evadm1	2025-09-29 16:21:13
Patient Info added/updated	Note:LAWYER KELVIN CALDWELL Eppinger Reingold&Korder 131 Larchmont Ave, Larchmont, NY 10538 (914) 833-0500;	Evadm1	2025-09-10 14:09:54
Patient Info added/updated	New Client created.	BestcareBronx	2025-09-09 17:14:57

Record (1.. 3) of 3

December 2025						
Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Future Appointments   
 Past Appointments

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

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

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

X Ruddy LIRIANO ("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 9/2/25, 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 Ruddy LIRIANO  
(Print name of Patient)

X Ruddy Liriano  
(Signature of Patient)

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

X 12/15/25  
(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)

12/15/25  
(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: \_\_\_\_\_

**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:** RUDDY LIRIANO  
**DATE OF BIRTH:** 12/31/1984  
**ID/MRN:** 20251215145850952  
**CLINICIAN:** DR. FIALKOV, ROSS  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 12/15/2025  
**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER

---

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

RIGHT SHOULDER: The bones and joints of the right shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

### IMPRESSION:

**Negative right shoulder.**

---

**Electronically Signed By:** Steven Brownstein MD 12/18/2025 20:26:15 EST

**Tech:** Dynamic Mobile Xray Services LLC

12/18/2025 10:34 PM



**DYNAMIC**  
MOBILE XRAY SERVICES LLC

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

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

**MOBILE PORTABLE X-RAY ORDER FORM**

DATE 12/15/04

**YOUR INFORMATION:**

NAME Ruddy Liriano D.O.B. 12/31/84 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><b>ABDOMEN</b> ..... KUB 1 view ..... <input type="checkbox"/> 74000 Complete 2 views ..... <input type="checkbox"/> 74020 Acute w/chest 3 views ..... <input type="checkbox"/> 74022</p> <p><b>AC JOINTS W/ &amp; W/O WEIGHTS</b> 2 views ..... <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views ..... <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> ..... 1 view ..... <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> .. Complete ..... <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72040 Complete w/min. 4 views ..... <input type="checkbox"/> 72050 Complete w/flex &amp; ext. 7 view <input type="checkbox"/> 72052</p> <p><b>CHEST</b> ..... Limited 1 view ..... <input type="checkbox"/> 71045 Complete 2 views ..... <input type="checkbox"/> 71046 Complete w/lordotic 3 views . <input type="checkbox"/> 71047 Complete 4 views ..... <input type="checkbox"/> 71048 Special views Decubitus ..... <input type="checkbox"/> 71035</p> <p><b>CLAVICLE</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p><b>ELBOW</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b> : Complete 3 or more views ..... <input type="checkbox"/> 70150</p> <p><b>FEMUR</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> . Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> ..... Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p><b>FOREARM</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hlp) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p><b>HUMERUS</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> ..... Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p><b>LUMBAR</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72100 Complete 4 views w/obl ..... <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p><b>MANDIBLE</b> .... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views ..... <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> .... Complete min. 3 views ..... <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> .. Comp. min. 3 views ..... <input type="checkbox"/> 70160</p> <p><b>NECK</b> ..... Soft tissue 2 views ..... <input type="checkbox"/> 70360</p> <p><b>ORBITS</b> ..... Complete 4 views ..... <input type="checkbox"/> 70200 MRI screening ..... <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170</p> <p><b>RIBS</b> ..... Unilateral 2 views ..... <input type="checkbox"/> 71100 3 views Includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views ..... <input type="checkbox"/> 71110 4 views Includes PA chest ..... <input type="checkbox"/> 71111</p>	<p><b>SACRUM &amp; COCCYX</b>. Min. 3 views ..... <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> ..... 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b> ..... 3 views ..... <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b> ..... Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p><b>SI JOINTS</b> ..... Complete, 2 views ..... <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> ..... Limited 2 or less ..... <input type="checkbox"/> 70210 Complete 3+ views ..... <input type="checkbox"/> 70220</p> <p><b>SKULL</b> ..... Limited 3 views or less ..... <input type="checkbox"/> 70250 Complete 4 views ..... <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> ..... Complete 2 views ..... <input type="checkbox"/> 71120</p> <p><b>THORACIC</b> ..... 3 views ..... <input type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b>. 2 views ..... <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b> Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b> ..... Bilateral open/closed ..... <input type="checkbox"/> 70330</p> <p><b>TOE #</b> ..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b></p> <p><b>EXTREMITY Lower</b>. 2 views ..... <input type="checkbox"/> 73592</p> <p><b>EXTREMITY Upper</b>. 2 views ..... <input type="checkbox"/> 73092</p> <p><b>PELVIS &amp; HIPS</b> .. min. 2 views ..... <input type="checkbox"/> 73540</p> <p><b>WRIST</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p><b>OTHER</b> _____ <input type="checkbox"/> 70000</p>
--	---	--

**REQUESTING PHYSICIAN:**

NAME Ross Fowler NPI# \_\_\_\_\_ FAX RESULTS TO ( ) \_\_\_\_\_

INDICATE REASON FOR STUDY R/O Ft post mva SIGNATURE [Signature]

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_

X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT \_\_\_\_/\_\_\_\_/\_\_\_\_ PATIENT ID # \_\_\_\_\_ # OF CD \_\_\_\_\_

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

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

### Elite Health & Wellness Center PC

- Work Area** ✕
- Patent Info
  - Billing Info
  - Date Billing
  - Bulk Billing
  - Create New Patient
  - Documents
  - Unmailed Bills
  - Unbilled Patients
  - No Answer in 45 days
  - Missing POMs/Fax POMs
  - Verifications
  - NF-2 Not Sent Report

Open Scanner

Templates

**[Quick Search]**

By Last Name

By Claim #

By Patient Id

**Verifications Available**

#	Request	Answer	Left	Bld

New

Patient Info (Id: 716)		Show All Diary Notes		Summary Note		Fields in red required for E-submission, Brown - for WC only.				GTX ID #
First Name	MIGUEL ALEJANDRO	Last Name	ARIAS	Sex:	▼	Height/Weight	ft	in	lbs	
Address	11 GRAY BIRCH RD	City,State,Zip	BLACKWOOD	N	▼	SSN/DOB:	707-8	05/25/1984		
Home Phone		Cell Phone	347-567-9233	Place Of Service	Bestcare Bronx					
Contact Info		Emer Phone		Email/CaseType	MIGUELARIAS19@GMAIL.CC	No-Fault	▼			
PtntToInsurd	Self	Office	Elite Health & Wellness Center PC	WC#/Prior #						
EmplrName/Ph		Emplr Address		Emplr City,St,Zp						
Insurance Co.	Progressive Northeastern Ins. Co.; 72	Insurance Claim #	25647271252	PT's Attorney	..Select..					
Adjuster	BAQI DAVIS	Adj. Phone/Fax	518-560-3705	NoWork Frm/To						
Insurd FName	MIGUEL ALEJANDRO	Insurd LName	ARIAS	Insurd DOB	05/25/1984					
Insurd Address	11 GRAY BIRCH RD	Insurd City,St,Zp	BLACKWOOD	N	▼	Policy#/MedID	854713561			
First Visit		DOA/State/Role	11/13/2025	N	▼	Driver	▼	Cntr Indication		
NF-2 Sent on		Confirmed	<input type="checkbox"/>	Status	OPEN			Cut Off Date:		Type: ..Select..
Referred By	..Select..	Policy Limit	..Select..	Totals:	Billed: 0.00; Balance: 0.00; Paid: 0.00; WriteOff: 0.00					
Comments	David Beck, ESQ Ph:518 388 7785 E: David@backlawny.com				Diagnosis 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. ..Select..					
<input type="button" value="Save Updates"/>		AOB Already Exists		MG2 Counter		MG2 Exp. Date		Missing document(s) for MAIL LOG: None		

**Tests Summary Information**

Test Date	Test Name	Comments	Provider	Delete
	..Select..		..Select..	<input type="button" value="Add"/>

**Notes Details (Showing up to 100 records)**

Records per Page: 150

Record (1.. 5) of 5

Notes Description	Notes Details	Edited By	Date Edited
Patient Info added/updated	CntCell:347-567-9233;	BestcareBronx	2025-12-08 11:23:01
Patient Info added/updated	Note:David Beck, ESQ Ph:518 388 7785 E: David@backlawny.com;	Evadlm1	2025-11-19 18:17:04
Patient Info added/updated	Note:David Beck, ESQ Ph:518 388 7785;	Evadlm1	2025-11-19 18:16:28
Patient Info added/updated	CntCell:858-436-2260;	BestcareBronx	2025-11-19 12:32:48
Patient Info added/updated	New Client created.	BestcareBronx	2025-11-17 18:01:18

Record (1.. 5) of 5

December							2025						
Su	Mo	Tu	Wa	Th	Fr	Sa	1	2	3	4	5	6	
7	8	9	10	11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30	31			

Future Appointments   
 Past Appointments

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

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

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

X Miguel ("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 Miguel  
(Print name of Patient)

X Miguel Cruz  
(Signature of Patient)

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

X 12/15/25  
(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)

12/15/25  
(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: Meghan Davis Date: 12/15/25

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_  
who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of  
said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this 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:** MIGUEL ARIAS  
**DATE OF BIRTH:** 05/25/1984  
**ID/MRN:** 20251215135821792  
**CLINICIAN:** DR. FIALKOV, ROSS  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 12/15/2025  
**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER, M25.512-PAIN IN LEFT SHOULDER

### LEFT SHOULDER X-Ray 1 view:

LEFT SHOULDER: The bones and joints of the left shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

### IMPRESSION:

**Negative left shoulder.**

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

RIGHT SHOULDER: The bones and joints of the right shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

### IMPRESSION:

**Negative right shoulder.**

**Electronically Signed By:** Steven Brownstein MD 12/18/2025 19:52:47 EST

Steven Brownstein

**Tech:** Dynamic Mobile Xray Services LLC

Steven Brownstein



**MOBILE PORTABLE X-RAY ORDER FORM**

DATE 12/18/25

**YOUR INFORMATION:**

NAME Wagner Arias D.O.B. 5/25/84 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><b>ABDOMEN</b> ..... KUB 1 view ..... <input type="checkbox"/> 74000          Complete 2 views ..... <input type="checkbox"/> 74020          Acute w/chest 3 views ..... <input type="checkbox"/> 74022</p> <p><b>AC JOINTS W/ &amp; W/O WEIGHTS</b>          2 views ..... <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600          Complete 3 views ..... <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> ..... 1 view ..... <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> .. Complete ..... <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72040          Complete w/min. 4 views ..... <input type="checkbox"/> 72050          Complete w/flex &amp; ext. 7 views ..... <input type="checkbox"/> 72052</p> <p><b>CHEST</b> ..... Limited 1 view ..... <input type="checkbox"/> 71045          Complete 2 views ..... <input type="checkbox"/> 71046          Complete w/lordotic 3 views ..... <input type="checkbox"/> 71047          Complete 4 views ..... <input type="checkbox"/> 71048          Special views Decubitus ..... <input type="checkbox"/> 71035</p> <p><b>CLAVICLE</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p><b>ELBOW</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b> .. Complete 3 or more views ..... <input type="checkbox"/> 70150</p> <p><b>FEMUR</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> ..... Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620          Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p><b>FOREARM</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510          Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p><b>HUMERUS</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> ..... Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560          Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562          Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564          Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p><b>LUMBAR</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72100          Complete 4 views w/obl ..... <input type="checkbox"/> 72110          Complete w/bending 7 views ..... <input type="checkbox"/> 72114          Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p><b>MANDIBLE</b> .... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100          Complete 4 views ..... <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> .... Complete min. 3 views ..... <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> .. Comp. min. 3 views ..... <input type="checkbox"/> 70160</p> <p><b>NECK</b> ..... Soft tissue 2 views ..... <input type="checkbox"/> 70360</p> <p><b>ORBITS</b> ..... Complete 4 views ..... <input type="checkbox"/> 70200          MRI screening ..... <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170</p> <p><b>RIBS</b> ..... Unilateral 2 views ..... <input type="checkbox"/> 71100          3 views Includes PA chest (trauma) <input type="checkbox"/> 71101          Bilateral, 3 views ..... <input type="checkbox"/> 71110          4 views includes PA chest ..... <input type="checkbox"/> 71111</p>	<p><b>SACRUM &amp; COCCYX</b>. Min. 3 views ..... <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> ..... 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b> ..... 3 views ..... <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b> ..... Complete, 2 views - R <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> 73030</p> <p><b>SI JOINTS</b> ..... Complete, 2 views ..... <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> ..... Limited 2 or less ..... <input type="checkbox"/> 70210          Complete 3+ views ..... <input type="checkbox"/> 70220</p> <p><b>SKULL</b> ..... Limited 3 views or less ..... <input type="checkbox"/> 70250          Complete 4 views ..... <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> ..... Complete 2 views ..... <input type="checkbox"/> 71120</p> <p><b>THORACIC</b> ..... 3 views ..... <input type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b>. 2 views ..... <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b>          Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b> ..... Bilateral open/closed ..... <input type="checkbox"/> 70330</p> <p><b>TOE #</b> ..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b></p> <p><b>EXTREMITY Lower</b>. 2 views ..... <input type="checkbox"/> 73592</p> <p><b>EXTREMITY Upper</b>. 2 views ..... <input type="checkbox"/> 73092</p> <p><b>PELVIS &amp; HIPS</b> .. min. 2 views ..... <input type="checkbox"/> 73540</p> <p><b>WRIST</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p><b>OTHER</b> ..... <input type="checkbox"/> 70000</p>
--	---	--

**REQUESTING PHYSICIAN:**

NAME Ross Fowler NPI# \_\_\_\_\_ FAX RESULTS TO ( ) \_\_\_\_\_  
 INDICATE REASON FOR STUDY R/O Ft post mva SIGNATURE [Signature]

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_  
 X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT / / \_\_\_\_\_ PATIENT ID # \_\_\_\_\_ # OF CD \_\_\_\_\_

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

### Elite Health & Wellness Center PC

- Work Area
- Patient Info
  - Billing Info
  - Date Billing
  - Bulk Billing
  - Create New Patient
  - Documents
  - Unmailed Bills
  - Unbilled Patients
  - No Answer in 45 days
  - Missing POMs/Fax POMs
  - Verifications
  - NF-2 Not Sent Report

Open Scanner

Templates

Quick Search

By Last Name

By Claim #

By Patient Id

Verifications Available

#	Request	1	Answer	Left	Bill
New					

Patient Info (Id: 709)		Show All Diary Notes		Summary Note		Fields in red required for E-submission. Brown - for WC only.				GTX ID #	
First Name	RAMON	Last Name	BURGOS	Sex:	M	Height/Weight	ft	in	lbs		
Address	3100 HEATH AVE 4B	City,State,Zip	BRONX NY 10463	SSN/DOB:	707-2	07/05/1986					
Home Phone		Cell Phone	332-270-5250	Place Of Service	Bestcare Bronx						
Contact Info		Emer Phone		Email/CaseType	ELBUFALO0586@GMAIL.COM   W.C.						
PtntToInsurd	Self	Office	Elite Health & Wellness Center PC	WC#/Prior #	G4252778						
EmplrName/Ph		Emplr Address		Emplr City,St,Zp	NY						
Insurance Co.	State Insurance Fund; PO BOX 66699	Insurance Claim #	75417063-126	PT's Attorney	..Select..						
Adjuster	ALEX BRUECKEL	Adj. Phone/Fax	631.756.4399	NoWork Frm/To							
Insurd FName	RAMON	Insurd LName	BURGOS	Sex:	M	Insurd DOB	07/05/1986				
Insrd Address	3100 HEATH AVE 4B	Insrd City,St,Zp	BRONX NY 10463	Policy#/MedID							
First Visit		DOA/State/Role	10/06/2025 NY Work Injury	Cntr Indication							
NF-2 Sent on	10/27/2025	Confirmed	<input type="checkbox"/>	Status	OPEN		Cut Off Date:		Type:	..Select..	
Referred By	..Select..	Policy Limit	..Select..	Totals:	Billed: 0.00; Balance: 0.00; Paid: 0.00; WriteOff: 0.00						
Comments	LAWYER: BORIS # 347-515-0407 W.C.						Diagnosis				
						1. <input type="text"/>					
						2. <input type="text"/>					
						3. <input type="text"/>					
						4. <input type="text"/>					
						5. <input type="text"/>					
						6. ..Select..					
<input type="button" value="Save Updates"/> AOB Already Exists. MG2 Counter MG2 Exp. Date <input type="text"/>						Missing document(s) for MAIL LOG: [Police report, NF2]					

Tests Summary Information

Test Date	Test Name	Comments	Provider	Delete
<input type="text"/>	..Select..	<input type="text"/>	..Select..	<input type="button" value="Add"/>

Notes Details (Showing up to 100 records)

Records per Page: 150

Record (1.. 5) of 5

Notes Description	Notes Details	Edited By	Date Edited
Patient Info added/updated	InsClaim:75417063-126; Insurd:83;	Evadlm1	2025-11-28 16:10:18
Client Info updated in all related offices	83; 75417063-126; Oct 6 2025 12:00AM; bestcare;	Evadlm1	2025-11-28 16:10:18
Patient Info added/updated	Note:LAWYER: BORIS # 347-515-0407 W.C;	Evadlm1	2025-10-27 15:54:05
Patient Info added/updated	Note:LAWYER: BORIS # 347-515-0407 W.C;	BestcareBronx	2025-10-27 15:14:43
Patient Info added/updated	New Client created.	Evadlm1	2025-10-27 14:34:28

Record (1.. 5) of 5

December 2025

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Future Appointments

Past Appointments

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

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

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

X Ramon ("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 10/06/25, 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 Ramon  
(Print name of Patient)

X Ramon Borsos  
(Signature of Patient)

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

X 12/15/25  
(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)

12/15/25  
(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: Ramon Burgos Date: 12/15/25

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_ who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this 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:** RAMON BURGOS  
**DATE OF BIRTH:** 07/05/1986  
**ID/MRN:** 20251215133109192  
**CLINICIAN:** DR. FIALKOV, ROSS  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 12/15/2025  
**HISTORY:** M25.562-PAIN IN LEFT KNEE

---

### 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 12/18/2025 19:51:52 EST

**Tech:** Dynamic Mobile Xray Services LLC



**DYNAMIC**  
MOBILE XRAY SERVICES LLC

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

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

**MOBILE PORTABLE X-RAY ORDER FORM**

DATE 12/25/25

**YOUR INFORMATION:**

NAME Ramon Burgos D.O.B. 7/5/86 SS# \_\_\_\_\_  MALE  FEMALE

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

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

PRIMARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

SECONDARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

**PROCEDURE: (Circle what is needed)**

<p><b>ABDOMEN</b> ..... KUB 1 view ..... <input type="checkbox"/> 74000 Complete 2 views ..... <input type="checkbox"/> 74020 Acute w/chest 3 views ..... <input type="checkbox"/> 74022</p> <p><b>AC JOINTS W/ &amp; W/O WEIGHTS</b> 2 views ..... <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views ..... <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> ..... 1 view ..... <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> .. Complete ..... <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72040 Complete w/min. 4 views ..... <input type="checkbox"/> 72050 Complete w/flex &amp; ext. 7 views ..... <input type="checkbox"/> 72052</p> <p><b>CHEST</b> ..... Limited 1 view ..... <input type="checkbox"/> 71045 Complete 2 views ..... <input type="checkbox"/> 71046 Complete w/lordotic 3 views ..... <input type="checkbox"/> 71047 Complete 4 views ..... <input type="checkbox"/> 71048 Special views Decubitus ..... <input type="checkbox"/> 71035</p> <p><b>CLAVICLE</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p><b>ELBOW</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b> .. Complete 3 or more views ..... <input type="checkbox"/> 70150</p> <p><b>FEMUR</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> ..... Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p><b>FOREARM</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p><b>HUMERUS</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> ..... Limited 1 or 2 views R <input type="checkbox"/> L <input 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><b>LUMBAR</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72100 Complete 4 views w/obl ..... <input type="checkbox"/> 72110 Complete w/bending 7 views ..... <input type="checkbox"/> 72114 Limited w/bending 4 views ..... <input type="checkbox"/> 72120</p> <p><b>MANDIBLE</b> .... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views ..... <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> .... Complete min. 3 views ..... <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> .. Comp. min. 3 views ..... <input type="checkbox"/> 70160</p> <p><b>NECK</b> ..... Soft tissue 2 views ..... <input type="checkbox"/> 70360</p> <p><b>ORBITS</b> ..... Complete 4 views ..... <input type="checkbox"/> 70200 MRI screening ..... <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170</p> <p><b>RIBS</b> ..... Unilateral 2 views ..... <input type="checkbox"/> 71100 3 views Includes PA chest (trauma) ..... <input type="checkbox"/> 71101 Bilateral, 3 views ..... <input type="checkbox"/> 71110 4 views includes PA chest ..... <input type="checkbox"/> 71111</p>	<p><b>SACRUM &amp; COCCYX</b>. Min. 3 views ..... <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> ..... 2 views - ..... R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b> ..... 3 views ..... <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b> ..... Complete, 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73030</p> <p><b>SI JOINTS</b> ..... Complete, 2 views ..... <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> ..... Limited 2 or less ..... <input type="checkbox"/> 70210 Complete 3+ views ..... <input type="checkbox"/> 70220</p> <p><b>SKULL</b> ..... Limited 3 views or less ..... <input type="checkbox"/> 70250 Complete 4 views ..... <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> ..... Complete 2 views ..... <input type="checkbox"/> 71120</p> <p><b>THORACIC</b> ..... 3 views ..... <input type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b>. 2 views ..... <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b> Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b> ..... Bilateral open/closed ..... <input type="checkbox"/> 70330</p> <p><b>TOE #</b> ..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b> ..... <input type="checkbox"/> 71150</p> <p><b>EXTREMITY Lower</b>. 2 views ..... <input type="checkbox"/> 73592</p> <p><b>EXTREMITY Upper</b>. 2 views ..... <input type="checkbox"/> 73092</p> <p><b>PELVIS &amp; HIPS</b> .. min. 2 views ..... <input type="checkbox"/> 73540</p> <p><b>WRIST</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p><b>OTHER</b> ..... <input type="checkbox"/> 71250</p>
---	---	--

**REQUESTING PHYSICIAN:**

NAME Ross Fowler NPI# \_\_\_\_\_ FAX RESULTS TO ( ) \_\_\_\_\_

INDICATE REASON FOR STUDY R/O Ft post mva SIGNATURE [Signature]

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_

X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT / / \_\_\_\_\_ PATIENT ID # \_\_\_\_\_ # OF CD \_\_\_\_\_

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

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

### Elite Health & Wellness Center PC

**Work Area** ✕

- Patient Info
- Billing Info
- Date Billing
- Bulk Billing
- Create New Patient
- Documents
- Unmailed Bills
- Unbilled Patients
- No Answer in 45 days
- Missing POMs/Fax POMs
- Verifications
- NF-2 Not Sent Report

**Open Scanner**

**Templates**

..Select.. ▼

**[Quick Search]**

By Last Name

By Claim #

By Patient Id

**Verifications Available**

# | Request | Answer | Left | Bill

New

Patient Info (Id: 722)		Show All Diary Notes		Summary Note		Fields in red required for E-submission. Brown - for WC only.				GTX ID #
First Name	MANUEL	Last Name	GERMAN PEREZ	Sex:	▼	Height/Weight	ft	in	lbs	
Address	2105 DALY AVE APT 30	City,State,Zip	NY	N	▼	SSN/DOB:	096-75-1776	07/20/1989		
Home Phone		Cell Phone	929-272-8405	Place Of Service	Bestcare Bronx					
Contact Info		Emer Phone		Email/CaseType					No-Fault	▼
PntToInsurd	Self	Office	Elite Health & Wellness Center PC	WC#/Prior #						
EmplrName/Ph		Emplr Address		Emplr City,St,Zp						
Insurance Co.	State Farm Fire And Casualty Compan	Insurance Claim #	3293M210V	PT's Attorney	..Select..					
Adjuster		Adj. Phone/Fax		NoWork Frm/To						
Insurd FName	MANUEL	Insurd LName	GERMAN PEREZ	Sex:	▼	Insurd DOB	07/20/1989			
Insrd Address	2105 DALY AVE APT 30	Insrd City,St,Zp	NY	N	▼	Policy#/MedID	2760419-C23-32C			
First Visit		DOA/State/Role	11/25/2025	N	▼	Driver	▼			
NF-2 Sent on		Confirmed	<input type="checkbox"/>	Status	OPEN					
Referred By	..Select..	Policy Limit	..Select..	Totals:	Billed: 0.00; Balance: 0.00; Paid: 0.00; WriteOff: 0.00					
Comments	LAW OFFICES OF DAVID FEINERMAN EMAIL: LAWOFFICE2765@GMAIL.COM TEL: (7180-646-4800) FAX: (718)-646-5770				Diagnosis 1. 2. 3. 4. 5. 6. ..Select..					
<input type="button" value="Save Updates"/>		AOB Already Exists. <input type="checkbox"/>		MG2 Counter <input type="checkbox"/>		MG2 Exp. Date <input type="text"/>		Missing document(s) for MAIL LOG: [Police report]		

December ▼							2025 ▼						
Su	Mo	Tu	We	Th	Fr	Sa	1	2	3	4	5	6	
7	8	9	10	11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30	31			

Future Appointments

Past Appointments

**Tests Summary Information**

Test Date	Test Name	Comments	Provider	Delete
	..Select..		..Select..	<input type="button" value="Add"/>

**Notes Details (Showing up to 100 records)**

Records per Page: 150

Record (1.. 5) of 5

Notes Description	Notes Details	Edited By	Date Edited
Patient Info added/updated	Note:LAW OFFICES OF DAVID FEINERMAN EMAIL: LAWOFFICE2765@GMAIL.COM TEL: (7180-646-4800) FAX: (718)-646-5770;	Evadim1	2025-12-12 15:22:51
Patient Info added/updated	Note:LAW OFFICES OF DAVID FEINERMAN EMAIL: LAWOFFICE2765@GMAIL.COM TEL: (7180-646-4800) FAX: (718)-646-5770;	BestcareBronx	2025-12-05 13:02:46
Patient Info added/updated	InsClaim:3293M210V;	BestcareBronx	2025-11-26 15:39:29
Client Info updated in all related offices	1074; 3293M210V; Nov 25 2025 12:00AM; bestcare;	BestcareBronx	2025-11-26 15:39:29
Patient Info added/updated	New Client created.	BestcareBronx	2025-11-26 15:38:06

Record (1.. 5) of 5

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

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

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

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

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

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

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO 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 Maud Berman  
(Print name of Patient)  
2105 DALY AVE BRONX  
NY 10460 30  
(Address of Patient)

X Maud Berman  
(Signature of Patient)  
12/15/25  
(Date of signature)

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

[Signature]  
(Signature of Provider)  
12/15/25  
(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: Mouad Ghermez Date: 12-15-2025

**Consent To X-Ray:**

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

Signed: Mouad Ghermez Date: 12-15-2025

**Females: Regarding Possibility of Pregnancy**

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

Signed: Mouad Ghermez Date: 12-15-2025

# DYNAMIC MOBILE XRAY SERVICES LLC

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

## Radiology Interpretation

**PATIENT NAME:** MANUEL GERMAN PEREZ

**DATE OF BIRTH:** 07/20/1989

**ID/MRN:** 20251215131022774

**CLINICIAN:** DR. FIALKOV, ROSS

**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC

**DATE OF EXAM:** 12/15/2025

**HISTORY:** M25.511-PAIN IN RIGHT SHOULDER, M25.512-PAIN IN LEFT SHOULDER, M25.561-PAIN IN RIGHT KNEE, M25.562-PAIN IN LEFT KNEE

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

LEFT SHOULDER: The bones and joints of the left shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

**IMPRESSION:**

**Negative left shoulder.**

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

RIGHT SHOULDER: The bones and joints of the right shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

**IMPRESSION:**

**Negative right shoulder.**

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

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

**IMPRESSION:**

**No significant abnormalities noted**

### RIGHT 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 12/18/2025 20:08:37 EST

**Tech:** Dynamic Mobile Xray Services LLC



# DYNAMIC

MOBILE XRAY SERVICES LLC

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

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

## MOBILE PORTABLE X-RAY ORDER FORM

DATE 12/25/23

### YOUR INFORMATION:

NAME Manuel German D.O.B. 7/20/89 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><b>ABDOMEN</b> ..... KUB 1 view ..... <input type="checkbox"/> 74000 Complete 2 views ..... <input type="checkbox"/> 74020 Acute w/chest 3 views ..... <input type="checkbox"/> 74022</p> <p><b>AC JOINTS W/ &amp; W/O WEIGHTS</b> 2 views ..... <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views ..... <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> ..... 1 view ..... <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> .. Complete ..... <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72040 Complete w/min. 4 views ..... <input type="checkbox"/> 72050 Complete w/flex &amp; ext. 7 views <input type="checkbox"/> 72052</p> <p><b>CHEST</b> ..... Limited 1 view ..... <input type="checkbox"/> 71045 Complete 2 views ..... <input type="checkbox"/> 71046 Complete w/lordotic 3 views <input type="checkbox"/> 71047 Complete 4 views ..... <input type="checkbox"/> 71048 Special views Decubitus ..... <input type="checkbox"/> 71035</p> <p><b>CLAVICLE</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p><b>ELBOW</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b> .. Complete 3 or more views ..... <input type="checkbox"/> 70150</p> <p><b>FEMUR</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> ..... Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p><b>FOREARM</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p><b>HUMERUS</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> ..... Limited 1 or 2 views R <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> 73560 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562 Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564 Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p><b>LUMBAR</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72100 Complete 4 views w/obl ..... <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p><b>MANDIBLE</b> .... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views ..... <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> .... Complete min. 3 views ..... <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> .. Comp. min. 3 views ..... <input type="checkbox"/> 70160</p> <p><b>NECK</b> ..... Soft tissue 2 views ..... <input type="checkbox"/> 70360</p> <p><b>ORBITS</b> ..... Complete 4 views ..... <input type="checkbox"/> 70200 MRI screening ..... <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170</p> <p><b>RIBS</b> ..... Unilateral 2 views ..... <input type="checkbox"/> 71100 3 views includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral, 3 views ..... <input type="checkbox"/> 71110 4 views includes PA chest ..... <input type="checkbox"/> 71111</p>	<p><b>SACRUM &amp; COCCYX</b>. Min. 3 views ..... <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> ..... 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b> ..... 3 views ..... <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b> ..... Complete, 2 views - R <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> 73030</p> <p><b>SI JOINTS</b> ..... Complete, 2 views ..... <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> ..... Limited 2 or less ..... <input type="checkbox"/> 70210 Complete 3+ views ..... <input type="checkbox"/> 70220</p> <p><b>SKULL</b> ..... Limited 3 views or less ..... <input type="checkbox"/> 70250 Complete 4 views ..... <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> ..... Complete 2 views ..... <input type="checkbox"/> 71120</p> <p><b>THORACIC</b> ..... 3 views ..... <input type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b>. 2 views ..... <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b> Complete 2 views ..... R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b> ..... Bilateral open/closed ..... <input type="checkbox"/> 70330</p> <p><b>TOE #</b> ..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b></p> <p><b>EXTREMITY Lower</b>. 2 views ..... <input type="checkbox"/> 73592</p> <p><b>EXTREMITY Upper</b>. 2 views ..... <input type="checkbox"/> 73092</p> <p><b>PELVIS &amp; HIPS</b> .. min. 2 views ..... <input type="checkbox"/> 73540</p> <p><b>WRIST</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p><b>OTHER</b> _____</p>
---	---	--

### REQUESTING PHYSICIAN:

NAME Ross F. Walker NPI# \_\_\_\_\_ FAX RESULTS TO ( ) \_\_\_\_\_

INDICATE REASON FOR STUDY R/O Ft post mva SIGNATURE [Signature]

### FOR OFFICE USE ONLY:

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_

X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT / / \_\_\_\_\_ PATIENT ID # \_\_\_\_\_ # OF CD \_\_\_\_\_

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

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

### Elite Health & Wellness Center PC

- Work Area
- Patient Info
  - Billing Info
  - Date Billing
  - Bulk Billing
  - Create New Patient
  - Documents
  - Unmailed Bills
  - Unbilled Patients
  - No Answer in 45 days
  - Missing POMs/Fax POMs
  - Verifications
  - NF-2 Not Sent Report

Open Scanner

Templates

**[Quick Search]**

By Last Name

By Claim #

By Patient Id

**Verifications Available**

#	Request	1	Answer	Left	Bill
New					

<b>Patient Info (Id: 674)</b>		<b>Show All Diary Notes</b>		<b>Summary Note</b>		<b>Fields in red required for E-submission. Brown - for WC only.</b>			<b>GTX ID #</b>
<b>First Name</b>	CARLOS ANDRES	<b>Last Name</b>	PENA TAVAREZ	<b>Sex:</b>	<input type="text" value="M"/>	<b>Height/Weight</b>	ft	in	lbs
<b>Address</b>	1830 ANDREWA AVE	<b>City,State,Zip</b>	BRONX	<b>SSN/DOB:</b>	675-72-6558	<input type="text" value="01/12/1983"/>			
<b>Home Phone</b>		<b>Cell Phone</b>	929-586-3517	<b>Place Of Service</b>	Bestcare Bronx				
<b>Contact Info</b>		<b>Emer Phone</b>		<b>Email/CaseType</b>	CARLOS.PENA.TAVARES@G... No-Fault				
<b>PtntToInsurd</b>	Self	<b>Office</b>	Elite Health & Wellness Center PC						
<b>EmpIrName/Ph</b>		<b>EmpIr Address</b>		<b>WC#/Prior #</b>					
<b>Insurance Co.</b>	Progressive Casualty Ins. Co; 725 BR	<b>Insurance Claim #</b>	25-216061943						
<b>Adjuster</b>		<b>Adj. Phone/Fax</b>		<b>PT's Attorney</b>	..Select..				
<b>Insurd FName</b>	CARLOS ANDRES	<b>Insurd LName</b>	PENA TAVAREZ	<b>Sex:</b>	<input type="text" value="M"/>	<b>Insurd DOB</b>	<input type="text" value="01/12/1983"/>		
<b>Insrd Address</b>	1830 ANDREWA AVE	<b>Insrd City,St,Zp</b>	BRONX	<b>Policy#/MedID</b>	863420614				
<b>First Visit</b>		<b>DOA/State/Role</b>	09/22/2025	<b>Passenger</b>	<input type="text" value="M"/>				
<b>NF-2 Sent on</b>		<b>Confirmed</b>	<input type="checkbox"/>	<b>Status</b>	OPEN				
<b>Referred By</b>	..Select..		<b>Policy Limit</b>	..Select..		<b>Totals:</b>	Billed: 0.00; Balance: 0.00; Paid: 0.00; WriteOff: 0.00		
<b>Comments</b>							<b>Diagnosis</b>		
							1. <input type="text"/>		
							2. <input type="text"/>		
							3. <input type="text"/>		
							4. <input type="text"/>		
							5. <input type="text"/>		
							6. ..Select..		
<b>Save Updates:</b>	AOB Already Exists.		<b>MG2 Counter</b>	<b>MG2 Exp. Date</b>	<input type="text"/>				
						<b>Missing document(s) for MAIL LOG: None</b>			

(December)							(2025)						
Su	Mo	Tu	We	Th	Fr	Sa	1	2	3	4	5	6	
7	8	9	10	11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30	31			

Future Appointments

Past Appointments

**Tests Summary Information**

Test Date	Test Name	Comments	Provider	Delete
<input type="text"/>	..Select..		..Select..	<input type="button" value="Add"/>

**Notes Details (Showing up to 100 records)**

Records per Page:

Record (1.. 6) of 6

Notes Description	Notes Details	Edited By	Date Edited
Patient Info added/updated	Insurd:627;	BestcareBronx	2025-09-25 12:31:42
Client Info updated in all related offices	627; 25-218081943; Sep 22 2025 12:00AM; bestcare;	BestcareBronx	2025-09-25 12:31:42
Patient Info added/updated	Policy:863420614;	BestcareBronx	2025-09-25 12:31:02
Patient Info added/updated	InsClaim:25-216061943;	BestcareBronx	2025-09-25 12:30:32
Client Info updated in all related offices	508; 25-216081943; Sep 22 2025 12:00AM; bestcare;	BestcareBronx	2025-09-25 12:30:32
Patient Info added/updated	New Client created.	BestcareBronx	2025-09-24 11:15:32

Record (1.. 6) of 6

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

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

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

X Carlos Pena, ("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 9/22/25, 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 Carlos Pena  
(Print name of Patient)  
1230 Andrews AV. APT 1  
Bronx NY 10453  
(Address of Patient)

X Carlos Pena  
(Signature of Patient)  
X 12/15/25  
(Date of signature)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

[Signature]  
(Signature of Provider)  
12/15/25  
(Date of signature)

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

**DYNAMIC MOBILE XRAY SERVICES LLC**

**3412 BLUESTONE LANE  
EAST STROUDSBURG PA 18301**

**X-Ray Consent Form**

**Patient Consent To X-Ray:**

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

Signed:         Cecilia Jeno         Date:         12/15/25        

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_  
who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of  
said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this 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:** CARLOS PENA  
**DATE OF BIRTH:** 01/12/1993  
**ID/MRN:** 20251215125141193  
**CLINICIAN:** DR. FIALKOV, ROSS  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 12/15/2025  
**HISTORY:** M54.6-PAIN IN THORACIC SPINE, M25.561-PAIN IN RIGHT KNEE

---

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

**RIGHT SHOULDER:** The bones and joints of the right shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

**IMPRESSION:**

**Negative right shoulder.**

---

**RIGHT 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 12/18/2025 19:50:59 EST

**Tech:** Dynamic Mobile Xray Services LLC



**DYNAMIC**  
MOBILE XRAY SERVICES LLC

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

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

**MOBILE PORTABLE X-RAY ORDER FORM**

DATE 12/18/23

**YOUR INFORMATION:**

NAME Carlos Perez D.O.B. 01/12/93 SS# \_\_\_\_\_  MALE  FEMALE  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE ( ) \_\_\_\_\_  
 FACILITY (IF APPLICABLE) \_\_\_\_\_ ROOM# (IA) \_\_\_\_\_ ADDRESS (IA) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 PRIMARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_  
 SECONDARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

**PROCEDURE: (Circle what is needed)**

<p><b>ABDOMEN</b> ..... KUB 1 view ..... <input type="checkbox"/> 74000          Complete 2 views ..... <input type="checkbox"/> 74020          Acute w/chest 3 views ..... <input type="checkbox"/> 74022</p> <p><b>AC JOINTS W/ &amp; W/O WEIGHTS</b>          2 views ..... <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600          Complete 3 views ..... <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> ..... 1 view ..... <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> .. Complete ..... <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72040          Complete w/min. 4 views ..... <input type="checkbox"/> 72050          Complete w/flex &amp; ext. 7 views ..... <input type="checkbox"/> 72052</p> <p><b>CHEST</b> ..... Limited 1 view ..... <input type="checkbox"/> 71045          Complete 2 views ..... <input type="checkbox"/> 71046          Complete w/tortotic 3 views ..... <input type="checkbox"/> 71047          Complete 4 views ..... <input type="checkbox"/> 71048          Special views Decubitus ..... <input type="checkbox"/> 71035</p> <p><b>CLAVICLE</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73008</p> <p><b>ELBOW</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b> .. Complete 3 or more views ..... <input type="checkbox"/> 70150</p> <p><b>FEMUR</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> ..... Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620          Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p><b>FOREARM</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510          Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p><b>HUMERUS</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> ..... Limited 1 or 2 views R <input 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><b>LUMBAR</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72100          Complete 4 views w/obl ..... <input type="checkbox"/> 72110          Complete w/bending 7 views ..... <input type="checkbox"/> 72114          Limited w/bending 4 views ..... <input type="checkbox"/> 72120</p> <p><b>MANDIBLE</b> .... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100          Complete 4 views ..... <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> .... Complete min. 3 views ..... <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> .. Comp. min. 3 views ..... <input type="checkbox"/> 70160</p> <p><b>NECK</b> ..... Soft tissue 2 views ..... <input type="checkbox"/> 70360</p> <p><b>ORBITS</b> ..... Complete 4 views ..... <input type="checkbox"/> 70200          MRI screening ..... <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170</p> <p><b>RIBS</b> ..... Unilateral 2 views ..... <input type="checkbox"/> 71100          3 views includes PA chest (trauma) <input type="checkbox"/> 71101          Bilateral, 3 views ..... <input type="checkbox"/> 71110          4 views Includes PA chest ..... <input type="checkbox"/> 71111</p>	<p><b>SACRUM &amp; COCCYX</b>. Min. 3 views ..... <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> ..... 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b> ..... 3 views ..... <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b> ..... Complete, 2 views - R <input checked="" type="checkbox"/> L <input type="checkbox"/> 73030</p> <p><b>SI JOINTS</b> ..... Complete, 2 views ..... <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> ..... Limited 2 or less ..... <input type="checkbox"/> 70210          Complete 3+ views ..... <input type="checkbox"/> 70220</p> <p><b>SKULL</b> ..... Limited 3 views or less ..... <input type="checkbox"/> 70250          Complete 4 views ..... <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> ..... Complete 2 views ..... <input type="checkbox"/> 71120</p> <p><b>THORACIC</b> ..... 3 views ..... <input type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b>. 2 views ..... <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b>          Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b> ..... Bilateral open/closed ..... <input type="checkbox"/> 70330</p> <p><b>TOE #</b> ..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b> ..... <input type="checkbox"/> 73180</p> <p><b>EXTREMITY Lower</b>. 2 views ..... <input type="checkbox"/> 73592</p> <p><b>EXTREMITY Upper</b>. 2 views ..... <input type="checkbox"/> 73092</p> <p><b>PELVIS &amp; HIPS</b> .. min. 2 views ..... <input type="checkbox"/> 73540</p> <p><b>WRIST</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p><b>OTHER</b> ..... <input type="checkbox"/> 73090</p>
--	---	--

**REQUESTING PHYSICIAN:**

NAME Ross Finkov NPI# \_\_\_\_\_ FAX RESULTS TO ( ) \_\_\_\_\_  
 INDICATE REASON FOR STUDY R/O Ft post mva SIGNATURE R

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_  
 X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT \_\_\_\_/\_\_\_\_/\_\_\_\_ PATIENT ID # \_\_\_\_\_ # OF CD \_\_\_\_\_

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

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

### Elite Health & Wellness Center PC

- Work Area**
- Patient Info
  - Billing Info
  - Date Billing
  - Bulk Billing
  - Create New Patient
  - Documents
  - Unmailed Bills
  - Unbilled Patients
  - No Answer in 45 days
  - Missing POMs/Fax POMs
  - Verifications
  - NF-2 Not Sent Report

Open Scanner

Templates

**[Quick Search]**

By Last Name

By Claim #

By Patient Id

**Verifications Available**

#	Request	1	Answer	Left	Bill
New					

Patient Info (Id: 673)		Show All Diary Notes		Summary Note		Fields In red required for E-submission. Brown - for WC only.			GTX ID #
First Name	GRISMEILY	Last Name	GARCIA	Sex:	F	Height/Weight	ft	in	lbs
Address	560 W 192 ST	City,State,Zip	NEW YORK	N°	10040	SSN/DOB:	966-9	02/16/1993	
Home Phone		Cell Phone	646-287-4996	Place Of Service	Bestcare Bronx				
Contact Info		Emer Phone		Email/CaseType	GRISMEILY.GARCIA93@GMA No-Fault				
PntToInsurd	Self	Office	Elite Health & Wellness Center PC	WC#/Prior #					
EmplrName/Ph		Emplr Address		Emplr City,St,Zp	NY				
Insurance Co.	Erie Ins. Co.; P.O. Box 2013 Mechanc	Insurance Claim #	A00007119873	PT's Attorney	..Select..				
Adjuster		Adj. Phone/Fax		NoWork Frm/To					
Insurd FName	GRISMEILY	Insurd LName	GARCIA	Sex:	F	Insurd DOB	02/16/1993		
Insrd Address	560 W 192 ST	Insrd City,St,Zp	NEW YORK	N°	10040	Policy# /MedID	Q09-1318661		
First Visit	09/23/2025	DOA/State/Role	09/14/2025	N°	Passenger	Cntn Indication			
NF-2 Sent on	<input type="text"/>	Confirmed	<input type="checkbox"/>	Status	OPEN	Cut Off Date:	<input type="text"/>	Type:	..Select..
Referred By	..Select..	Policy Limit	..Select..	Totals:	Billed: 0.00; Balance: 0.00; Paid: 0.00; WriteOff: 0.00				
Comments	GARBER LAW # 516-360-9101					Diagnosis			
						1. _____			
						2. _____			
						3. _____			
						4. _____			
						5. _____			
						6. ..Select..			
<input type="button" value="Save Updates"/>	AOB Already Exsts. MG2 Counter <input type="text"/> MG2 Exp. Date <input type="text"/>					Missing document(s) for MAIL LOG: [Police report]			

**Tests Summary Information**

Test Date	Test Name	Comments	Provider	Delete
<input type="text"/>	..Select..		..Select..	<input type="button" value="Add"/>

**Notes Details (Showing up to 100 records)**

Records per Page:

Record (1.. 3) of 3

Notes Description	Notes Details	Edited By	Date Edited
Patient Info added/updated	Note:GARBER LAW # 516-360-9101;	BestcareBronx	2025-11-21 16:16:15
Patient Info added/updated	Note:GARVER LAW # 516-360-9101;	BestcareBronx	2025-10-01 14:22:21
Patient Info added/updated	New Client created.	Evadim1	2025-09-23 14:46:37

Record (1.. 3) of 3

December							2025						
Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6							
7	8	9	10	11	12	13							
14	15	16	17	18	19	20							
21	22	23	24	25	26	27							
28	29	30	31										

Future Appointments

Past Appointments

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

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

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

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

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and  
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained  
due to the motor vehicle accident which occurred on 9-24-25, 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 Grismely Garcia  
(Print name of Patient)

560 W 192ST Apt:4D

New York NY 10040  
(Address of Patient)

DYNAMIC MOBILE XRAY SERVICES  
(Print name of Provider)

3412 BLUESTONE LANE

EAST STROUDSBURG PA 18301  
(Address of Provider)

X Grismely Garcia  
(Signature of Patient)

X 12/15/25  
(Date of signature)

[Signature]  
(Signature of Provider)

12/15/25  
(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: Erismely Garcia Date: 12-15-25

**Consent To X-Ray:**

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

Signed: Erismely Garcia Date: 12-15-25

**Females: Regarding Possibility of Pregnancy**

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

Signed: Erismely Garcia Date: 12-15-25

# DYNAMIC MOBILE XRAY SERVICES LLC

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

13

## Radiology Interpretation

**PATIENT NAME:** GARCIA GRIMELLY  
**DATE OF BIRTH:** 02/16/1993  
**ID/MRN:** 20251215124532405  
**CLINICIAN:** DR. FIALKOV, ROSS  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 12/15/2025  
**HISTORY:** M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER, M25.512-PAIN IN LEFT SHOULDER

### SPINE THORACIC X-RAY 2 view:

Mild scoliosis and spondylosis dorsal spine noted. No fracture noted. No paraspinal soft tissue mass noted.

### IMPRESSION:

**Scoliosis and spondylosis noted.**

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

LEFT SHOULDER: The bones and joints of the left shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

### IMPRESSION:

**Negative left shoulder.**

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

RIGHT SHOULDER: The bones and joints of the right shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

### IMPRESSION:

**Negative right shoulder.**

**Electronically Signed By:** Steven Brownstein MD 12/18/2025 19:50:24 EST

**Tech:** Dynamic Mobile Xray Services LLC



**DYNAMIC**  
MOBILE XRAY SERVICES LLC

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

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

**MOBILE PORTABLE X-RAY ORDER FORM**

DATE 12/15/23

**YOUR INFORMATION:**

NAME Gail G. Grinnell D.O.B. 2/16/93 SS# \_\_\_\_\_  MALE  FEMALE

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

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

PRIMARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

SECONDARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

**PROCEDURE: (Circle what is needed)**

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

**REQUESTING PHYSICIAN:**

NAME Ross F. Walker NPI# \_\_\_\_\_ FAX RESULTS TO ( ) \_\_\_\_\_

INDICATE REASON FOR STUDY R/O Ft post MVA SIGNATURE [Signature]

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_

X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT \_\_\_\_/\_\_\_\_/\_\_\_\_ PATIENT ID # \_\_\_\_\_ # OF CD \_\_\_\_\_

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

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

### Elite Health & Wellness Center PC

- Work Area**
- Patient Info
  - Billing Info
  - Date Billing
  - Bulk Billing
  - Create New Patient
  - Documents
  - Unmailed Bills
  - Unbilled Patients
  - No Answer in 45 days
  - Missing POMs/Fax POMs
  - Verifications
  - NF-2 Not Sent Report

Open Scanner

Templates

**(Quick Search)**

By Last Name

By Claim #

By Patient Id

**Verifications Available**

#	Request	Answer	Left	Bill
New				

<b>Patient Info (Id: 675)</b>		<b>Show All Diary Notes</b>		<b>Summary Note</b>		<b>Fields in red required for E-submission. Brown - for WC only.</b>				<b>GTX ID #</b>		
<b>First Name</b>	ANTONIO	<b>Last Name</b>	POLANCO	<b>Sex:</b>	M	<b>Height/Weight:</b>	ft	in	lbs			
<b>Address</b>	2133 DALY AVE	<b>City,State,Zip</b>	BRONX	<b>N</b>	10460	<b>SSN/DOB:</b>	SSN	04/19/1979				
<b>Home Phone</b>		<b>Cell Phone</b>	347-283-3579	<b>Place Of Service</b>	Bestcare Bronx							
<b>Contact Info</b>		<b>Emer Phone</b>		<b>Email/CaseType</b>	..Select..							
<b>PtntToInsurd</b>	Self	<b>Office</b>	Elite Health & Wellness Center PC	<b>WC#/Prior #</b>								
<b>EmplrName/Ph</b>		<b>Emplr Address</b>		<b>Emplr City,St,Zp</b>	N							
<b>Insurance Co.</b>	Progressive Casualty Ins. Co; 725 BR	<b>Insurance Claim #</b>	25-216061943	<b>PT's Attorney</b>	..Select..							
<b>Adjuster</b>		<b>Adj. Phone/Fax</b>		<b>NoWork Frm/To</b>								
<b>Insurd FName</b>	ANTONIO	<b>Insurd LName</b>	POLANCO	<b>Sex:</b>	M	<b>Insurd DOB</b>	04/19/1979					
<b>Insrd Address</b>	2133 DALY AVE	<b>Insrd City,St,Zp</b>	BRONX	<b>N</b>	10460	<b>Policy#/MedID</b>	863420614					
<b>First Visit</b>	09/24/2025	<b>DOA/State/Role</b>	09/22/2025	<b>N</b>	Passenger	<b>Cntr Indication</b>						
<b>NF-2 Sent on</b>	<input type="text"/>	<b>Confirmed</b>	<input type="checkbox"/>	<b>Status</b>	OPEN		<b>Cut Off Date:</b>	<input type="text"/>				
<b>Referred By</b>	..Select..		<b>Policy Limit</b>	..Select..		<b>Totals:</b>	Billed: 0.00; Balance: 0.00; Paid: 0.00; WriteOff: 0.00					
<b>Comments</b>	DAVID FEINERMAN Ph: 718-646-4800 Fax: 718-646-5770						<b>Diagnosis</b> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. ..Select..					
<b>Save Updates:</b>		AOB Already Exists.		<b>MG2 Counter</b>	<input type="text"/>	<b>MG2 Exp. Date</b>	<input type="text"/>					
<b>Missing document(s) for MAIL LOG: None</b>												

**Tests Summary Information**

Test Date	Test Name	Comments	Provider	Delete
<input type="text"/>	..Select..	<input type="text"/>	..Select..	<input type="button" value="Add"/>

**Notes Details (Showing up to 100 records)**

Records per Page:

Record (1.. 6) of 6

Notes Description	Notes Details	Edited By	Date Edited
Patient Info added/updated	Note:DAVID FEINERMAN Ph: 718-646-4800 Fax: 718-646-5770;	EvadM1	2025-10-27 12:20:18
Patient Info added/updated	InsClaim:25-216061943;	BestcareBronx	2025-09-25 12:30:18
Client Info updated in all related offices	627; 25-216061943; Sep 22 2025 12:00AM; bestcare;	BestcareBronx	2025-09-25 12:30:16
Patient Info added/updated	Insurd:627; Policy:863420614;	BestcareBronx	2025-09-25 12:24:51
Client Info updated in all related offices	627; ; Sep 22 2025 12:00AM; bestcare;	BestcareBronx	2025-09-25 12:24:51
Patient Info added/updated	New Client created.	BestcareBronx	2025-09-24 11:18:57

Record (1.. 6) of 6

(December)							(2025)						
Su	Mo	Tu	We	Th	Fr	Sa	1	2	3	4	5	6	
7	8	9	10	11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30	31			

Future Appointments   
 Past Appointments

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

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

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

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

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

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

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO 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 ANTONIO POLANCO  
(Print name of Patient)

X Antonio Polanco  
(Signature of Patient)

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

X 12/15/25  
(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)

12/15/25  
(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: Antonio Palanca Date: 12/15/25

**Consent To X-Ray:**

A Minor I am a parent or legal guardian of \_\_\_\_\_  
who is a minor, \_\_\_\_\_ years of age. I hereby authorize the performance of diagnostic x-rays of  
said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this 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:** ANTONIO POLANCO  
**DATE OF BIRTH:** 04/19/1979  
**ID/MRN:** 20251215123855285  
**CLINICIAN:** DR. FIALKOV, ROSS  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 12/15/2025  
**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:

**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.

### IMPRESSION:

**Negative dorsal spine.**

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

**LEFT SHOULDER:** The bones and joints of the left shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

### IMPRESSION:

**Negative left shoulder.**

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

Hypertrophic spur formation off the patella identified. No fracture or subluxation noted. No abnormal masses or calcifications noted.

### IMPRESSION:

**Hypertrophic spur formation off the patella noted**

**Electronically Signed By:** Steven Brownstein MD 12/18/2025 19:47:54 EST

**Tech:** Dynamic Mobile Xray Services LLC



**DYNAMIC**  
MOBILE XRAY SERVICES LLC

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

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

**MOBILE PORTABLE X-RAY ORDER FORM**

DATE 12-15-20

**YOUR INFORMATION:**

NAME Antonio Polanco D.O.B. 4/19/79 SS# \_\_\_\_\_  MALE  FEMALE

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

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

PRIMARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

SECONDARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

**PROCEDURE: (Circle what is needed)**

<p><b>ABDOMEN</b> ..... KUB 1 view ..... <input type="checkbox"/> 74000 Complete 2 views ..... <input type="checkbox"/> 74020 Acute w/chest 3 views ..... <input type="checkbox"/> 74022</p> <p><b>AC JOINTS W/ &amp; W/O WEIGHTS</b> 2 views ..... <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600 Complete 3 views ..... <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> ..... 1 view ..... <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> .. Complete ..... <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72040 Complete w/min. 4 views ..... <input type="checkbox"/> 72050 Complete w/flex &amp; ext. 7 views <input type="checkbox"/> 72052</p> <p><b>CHEST</b> ..... Limited 1 view ..... <input type="checkbox"/> 71045 Complete 2 views ..... <input type="checkbox"/> 71046 Complete w/lordotic 3 views .. <input type="checkbox"/> 71047 Complete 4 views ..... <input type="checkbox"/> 71048 Special views Decubitus ..... <input type="checkbox"/> 71035</p> <p><b>CLAVICLE</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p><b>ELBOW</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b>.. Complete 3 or more views ..... <input type="checkbox"/> 70150</p> <p><b>FEMUR</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> ..... Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620 Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p><b>FOREARM</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510 Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p><b>HUMERUS</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> ..... Limited 1 or 2 views R <input type="checkbox"/> L <input 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><b>LUMBAR</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72100 Complete 4 views w/obl ..... <input type="checkbox"/> 72110 Complete w/bending 7 views <input type="checkbox"/> 72114 Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p><b>MANDIBLE</b> ..... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100 Complete 4 views ..... <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> ..... Complete min. 3 views ..... <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> .. Comp. min. 3 views ..... <input type="checkbox"/> 70160</p> <p><b>NECK</b> ..... Soft tissue 2 views ..... <input type="checkbox"/> 70360</p> <p><b>ORBITS</b> ..... Complete 4 views ..... <input type="checkbox"/> 70200 MRI screening ..... <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170</p> <p><b>RIBS</b> ..... Unilateral 2 views ..... <input type="checkbox"/> 71100 3 views Includes PA chest (trauma) <input type="checkbox"/> 71101 Bilateral; 3 views ..... <input type="checkbox"/> 71110 4 views Includes PA chest ..... <input type="checkbox"/> 71111</p>	<p><b>SACRUM &amp; COCCYX</b>. Min. 3 views ..... <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> ..... 2 views -- R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b> ..... 3 views ..... <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b> ... Complete, 2 views - R <input type="checkbox"/> L <input checked="" type="checkbox"/> 73030</p> <p><b>SI JOINTS</b> ..... Complete, 2 views ..... <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> ..... Limited 2 or less ..... <input type="checkbox"/> 70210 Complete 3+ views ..... <input type="checkbox"/> 70220</p> <p><b>SKULL</b> ..... Limited 3 views or less ..... <input type="checkbox"/> 70250 Complete 4 views ..... <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> ..... Complete 2 views ..... <input type="checkbox"/> 71120</p> <p><b>THORACIC</b> ... 2 views ..... <input checked="" type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b>. 2 views ..... <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b> Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b> ..... Bilateral open/closed ..... <input type="checkbox"/> 70330</p> <p><b>TOE #</b> ..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b> ..... <input type="checkbox"/> 71100</p> <p><b>EXTREMITY Lower</b>. 2 views ..... <input type="checkbox"/> 73592</p> <p><b>EXTREMITY Upper</b>. 2 views ..... <input type="checkbox"/> 73092</p> <p><b>PELVIS &amp; HIPS</b> .. min. 2 views ..... <input type="checkbox"/> 73540</p> <p><b>WRIST</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p><b>OTHER</b> ..... <input type="checkbox"/> 70000</p>
---	--	---

**REQUESTING PHYSICIAN:**

NAME Ross Fialkow NPI# \_\_\_\_\_ FAX RESULTS TO ( ) \_\_\_\_\_

INDICATE REASON FOR STUDY R/O Ft post mva SIGNATURE [Signature]

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_

X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT / / \_\_\_\_\_ PATIENT ID # \_\_\_\_\_ # OF CD \_\_\_\_\_

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

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

### Elite Health & Wellness Center PC

- Work Area
- Patient Info
- Billing Info
- Date Billing
- Bulk Billing
- Create New Patient
- Documents
- Unmailed Bills
- Unbilled Patients
- No Answer In 45 days
- Missing POMs/Fax POMs
- Verifications
- NF-2 Not Sent Report

Open Scanner

Templates

**Quick Search**

By Last Name

By Claim #

By Patient Id

**Verifications Available**

# | Request | Answer | Left | Bill |  
 New

<b>Patient Info (Id: 653)</b>		<b>Show All Diary Notes</b>		<b>Summary Note</b>		<b>Fields in red required for E-submission, Brown - for WC only.</b>			<b>GTK ID #</b>
<b>First Name</b>	JOHN EVARISTO	<b>Last Name</b>	CARRASCO MEJIA	<b>Sex:</b>	<input type="text" value="M"/>	<b>Height/Weight</b>	ft	in	lbs
<b>Address</b>	370 FORT WASHINGTON AVE	<b>City,State,Zip</b>	MANHATTAN NY 10033	<b>SSN/DOB:</b>	810-99-0505	09/11/1994			
<b>Home Phone</b>		<b>Cell Phone</b>	917-985-1956	<b>Place Of Service</b>	Bestcare Bronx				
<b>Contact Info</b>	RAFEL	<b>Emer Phone</b>	201-918-8607	<b>Email/CaseType</b>	CARRASCOLIAM23@GMAIL..Select.				
<b>PtntToInsurd</b>	Self	<b>Office</b>	Elite Health & Wellness Center PC	<b>WC#/Prior #</b>					
<b>EmplrName/Ph</b>		<b>Emplr Address</b>		<b>Emplr City,St,Zp</b>	NY				
<b>Insurance Co.</b>	Progressive Casualty Ins. Co; 725 BR	<b>Insurance Claim #</b>	25806947728	<b>PT's Attorney</b>	..Select..				
<b>Adjuster</b>		<b>Adj. Phone/Fax</b>		<b>NoWork Frm/To</b>					
<b>Insurd FName</b>	JOHN EVARISTO	<b>Insurd LName</b>	CARRASCO MEJIA	<b>Sex:</b>	<input type="text" value="M"/>	<b>Insurd DOB</b>	09/11/1994		
<b>Insrd Address</b>	370 FORT WASHINGTON AVE	<b>Insrd City,St,Zp</b>	MANHATTAN NY 10033	<b>Policy#/MedID</b>	996887423				
<b>First Visit</b>		<b>DOA/State/Role</b>	09/08/2025 NY Passenger	<b>Cntr Indication</b>					
<b>NF-2 Sent on</b>	<input type="text"/>	<b>Confirmed</b>	<input type="checkbox"/>	<b>Status</b>	OPEN		<b>Cut Off Date:</b>	<input type="text"/>	<b>Type:</b>
<b>Referred By</b>	..Select.		<b>Policy Limit</b>	..Select.		<b>Totals:</b>	Billed: 0.00; Balance: 0.00; Paid: 0.00; WriteOff: 0.00		
<b>Comments</b>	Davidov & Cohen law Ph: 718 328 8001						<b>Diagnosis</b>		
							1. <input type="text"/>		
							2. <input type="text"/>		
							3. <input type="text"/>		
							4. <input type="text"/>		
							5. <input type="text"/>		
							6. ...Select..		
<b>Save Updates</b>	AOB Already Exists.		<b>MG2 Counter</b>	<input type="text"/>	<b>MG2 Exp. Date</b>	<input type="text"/>	<b>Missing document(s) for MAIL LOG: [Police report]</b>		

**Tests Summary Information**

Test Date	Test Name	Comments	Provider	Delete
<input type="text"/>	..Select.		..Select.	<input type="button" value="Add"/>

**Notes Details (Showing up to 100 records)**

Records per Page:

Record (1.. 5) of 5

Notes Description	Notes Details	Edited By	Date Edited
Patient Info added/updated	Note:Davidov & Cohen law Ph: 718 328 8001;	Evadm1	2025-12-01 15:22:37
Patient Info added/updated	FName:JOHN EVARISTO; InsuredFName:JOHN EVARISTO;	BestcareBronx	2025-10-08 11:02:31
Patient Info added/updated	InsurdId:627;	Evadm1	2025-09-09 17:39:27
Client info updated in all rajated offices	627; 25806947728; Sep 8 2025 12:00AM; bestcare;	Evadm1	2025-09-09 17:39:27
Patient Info added/updated	New Client created.	BestcareBronx	2025-09-09 17:20:19

Record (1.. 5) of 5

December							2025						
Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6	7	8	9	10	11	12	13
14	15	16	17	18	19	20	21	22	23	24	25	26	27
28	29	30	31										

Future Appointments

Past Appointments

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

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

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

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

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

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

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO 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 JOHNEVARISTO Carrasco Mejia  
(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 EVARISTO  
(Signature of Patient)

X 12/15/25  
(Date of signature)

[Signature]  
(Signature of Provider)

12/15/25  
(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: EVARISTO Date: 15/12/25

**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:** JOHN CARRASCO  
**DATE OF BIRTH:** 09/11/1994  
**ID/MRN:** 20251215122042551  
**CLINICIAN:** DR. FIALKOV, ROSS  
**FACILITY:** DYNAMIC MOBILE XRAY SERVICES LLC  
**DATE OF EXAM:** 12/15/2025  
**HISTORY:** M54.6-PAIN IN THORACIC SPINE, M25.511-PAIN IN RIGHT SHOULDER, M25.512-PAIN IN LEFT SHOULDER

---

### 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.

### IMPRESSION:

**Negative dorsal spine.**

---

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

**LEFT SHOULDER:** The bones and joints of the left shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

### IMPRESSION:

**Negative left shoulder.**

---

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

**RIGHT SHOULDER:** The bones and joints of the right shoulder appear normal. There is no evidence of fracture, dislocation or separation. There are no soft tissue calcifications

### IMPRESSION:

**Negative right shoulder.**

---

**Electronically Signed By:** Steven Brownstein MD 12/18/2025 19:43:54 EST

**Tech:** Dynamic Mobile Xray Services LLC



**DYNAMIC**  
MOBILE XRAY SERVICES LLC

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

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

**MOBILE PORTABLE X-RAY ORDER FORM**

DATE 12/25/25

**YOUR INFORMATION:**

NAME JOHN CARASCO D.O.B. 9/11/19 SS# \_\_\_\_\_  MALE  FEMALE  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE ( ) \_\_\_\_\_  
 FACILITY (IF APPLICABLE) \_\_\_\_\_ ROOM# (IA) \_\_\_\_\_ ADDRESS (IA) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 PRIMARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_  
 SECONDARY INSURANCE NAME \_\_\_\_\_ INSURANCE ID # \_\_\_\_\_

**PROCEDURE: (Circle what is needed)**

<p><b>ABDOMEN</b> ..... KUB 1 view ..... <input type="checkbox"/> 74000          Complete 2 views ..... <input type="checkbox"/> 74020          Acute w/chest 3 views ..... <input type="checkbox"/> 74022</p> <p><b>AC JOINTS W/ &amp; W/O WEIGHTS</b>          2 views ..... <input type="checkbox"/> 73050</p> <p><b>ANKLE</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73600          Complete 3 views ..... <input type="checkbox"/> 73610</p> <p><b>BONE AGE</b> ..... 1 view ..... <input type="checkbox"/> 77072</p> <p><b>BONE SURVEY</b> .. Complete ..... <input type="checkbox"/> 77075</p> <p><b>CERVICAL</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72040          Complete w/min. 4 views ..... <input type="checkbox"/> 72050          Complete w/flex &amp; ext. 7 views ..... <input type="checkbox"/> 72052</p> <p><b>CHEST</b> ..... Limited 1 view ..... <input type="checkbox"/> 71045          Complete 2 views ..... <input type="checkbox"/> 71046          Complete w/lordotic 3 views ..... <input type="checkbox"/> 71047          Complete 4 views ..... <input type="checkbox"/> 71048          Special views Decubitus ..... <input type="checkbox"/> 71035</p> <p><b>CLAVICLE</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73000</p> <p><b>ELBOW</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73080</p> <p><b>FACIAL BONES</b> .. Complete 3 or more views ..... <input type="checkbox"/> 70150</p> <p><b>FEMUR</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73550</p> <p><b>FINGER(S) #</b> .. Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73140</p> <p><b>FOOT</b> ..... Weight bearing 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73620          Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73630</p> <p><b>FOREARM</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73090</p>	<p><b>HAND</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73130</p> <p><b>HEEL</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73650</p> <p><b>HIP</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73510          Bilateral 2 views (each hip) - R <input type="checkbox"/> L <input type="checkbox"/> 73520</p> <p><b>HUMERUS</b> ..... Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73060</p> <p><b>KNEE</b> ..... Limited 1 or 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73560          Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73562          Complete 4 views - R <input type="checkbox"/> L <input type="checkbox"/> 73564          Both knees, AP standing - R <input type="checkbox"/> L <input type="checkbox"/> 73565</p> <p><b>LUMBAR</b> ..... Limited 2 or 3 views ..... <input type="checkbox"/> 72100          Complete 4 views w/obl ..... <input type="checkbox"/> 72110          Complete w/bending 7 views ..... <input type="checkbox"/> 72114          Limited w/bending 4 views... <input type="checkbox"/> 72120</p> <p><b>MANDIBLE</b> .... Limited 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 70100          Complete 4 views ..... <input type="checkbox"/> 70110</p> <p><b>MASTOIDS</b> .... Complete min. 3 views ..... <input type="checkbox"/> 70130</p> <p><b>NASAL BONES</b> .. Comp. min. 3 views ..... <input type="checkbox"/> 70160</p> <p><b>NECK</b> ..... Soft tissue 2 views ..... <input type="checkbox"/> 70360</p> <p><b>ORBITS</b> ..... Complete 4 views ..... <input type="checkbox"/> 70200          MRI screening ..... <input type="checkbox"/> 70030</p> <p><b>PELVIS</b> ..... Complete 1 or 2 views ..... <input type="checkbox"/> 72170</p> <p><b>RIBS</b> ..... Unilateral 2 views ..... <input type="checkbox"/> 71100          3 views includes PA chest (trauma) <input type="checkbox"/> 71101          Bilateral, 3 views ..... <input type="checkbox"/> 71110          4 views includes PA chest ..... <input type="checkbox"/> 71111</p>	<p><b>SACRUM &amp; COCCYX</b>. Min. 3 views ..... <input type="checkbox"/> 72220</p> <p><b>SCAPULA</b> ..... 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73010</p> <p><b>SC JOINTS</b> ..... 3 views ..... <input type="checkbox"/> 71130</p> <p><b>SHOULDER</b> ..... Complete, 2 views - R <input checked="" type="checkbox"/> L <input checked="" type="checkbox"/> 73030</p> <p><b>SI JOINTS</b> ..... Complete, 2 views ..... <input type="checkbox"/> 72200</p> <p><b>SINUSES</b> ..... Limited 2 or less ..... <input type="checkbox"/> 70210          Complete 3+ views ..... <input type="checkbox"/> 70220</p> <p><b>SKULL</b> ..... Limited 3 views or less ..... <input type="checkbox"/> 70250          Complete 4 views ..... <input type="checkbox"/> 70260</p> <p><b>STERNUM</b> ..... Complete 2 views ..... <input type="checkbox"/> 71120</p> <p><b>THORACIC</b> ..... 2 views ..... <input checked="" type="checkbox"/> 72072</p> <p><b>THORACOLUMBAR</b>. 2 views ..... <input type="checkbox"/> 72080</p> <p><b>TIBIA/FIBULA (LOWER LEG)</b>          Complete 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73590</p> <p><b>TMJ</b> ..... Bilateral open/closed ..... <input type="checkbox"/> 70330</p> <p><b>TOE #</b> ..... Complete min. 2 views R <input type="checkbox"/> L <input type="checkbox"/> 73660</p> <p><b>WRIST</b> ..... Complete 3 views - R <input type="checkbox"/> L <input type="checkbox"/> 73110</p> <p><b>INFANT X-RAY</b></p> <p><b>EXTREMITY Lower</b>. 2 views ..... <input type="checkbox"/> 73592</p> <p><b>EXTREMITY Upper</b>. 2 views ..... <input type="checkbox"/> 73092</p> <p><b>PELVIS &amp; HIPS</b> .. min. 2 views ..... <input type="checkbox"/> 73540</p> <p><b>WRIST</b> ..... Limited 2 views - R <input type="checkbox"/> L <input type="checkbox"/> 73100</p> <p><b>OTHER</b> _____ <input type="checkbox"/> 70000</p>
--	---	---

**REQUESTING PHYSICIAN:**

NAME ROSS Favalora NPI# \_\_\_\_\_ FAX RESULTS TO ( ) \_\_\_\_\_  73059  
 INDICATE REASON FOR STUDY R/O Ft post mva SIGNATURE [Signature]

**FOR OFFICE USE ONLY:**

TECHNICIAN \_\_\_\_\_ TECHNIQUE \_\_\_\_\_ # OF VIEWS \_\_\_\_\_  
 X-RAY SENT TO RADIOLOGIST \_\_\_\_\_ DATE X-RAY SENT \_\_\_\_/\_\_\_\_/\_\_\_\_ PATIENT ID # \_\_\_\_\_ # OF CD \_\_\_\_\_

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

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