15. REPORT OF SERVICES RENDERED — ATTACH ADDITIONAL SHEETS IF NECESSARY  DATE OF PLACE OF SERVICE IDESCRIPTION OF TREATMENT OR PLACE OF SERVICE INCLUMING ZIP CODE  1/12/24 136-21 QUIDENS BLVD BRIARWOOD, NY MRI Cervical spine x 0 72141 \$5967.70  1/12/24 136-21 QUIDENS BLVD BRIARWOOD, NY MRI Lumbar spine x 0 72148 \$1,003.20  TOTAL CHARGES TO DATE: \$1,970.90  1/12/24 136-21 QUIDENS BLVD BRIARWOOD, NY MRI Lumbar spine x 0 72148 \$1,003.20  TOTAL CHARGES TO DATE: \$1,970.90  1/12/24 136-21 QUIDENS BLVD BRIARWOOD, NY MRI Lumbar spine x 0 72148 \$1,003.20  TOTAL CHARGES TO DATE: \$1,970.90  1/12/24 136-21 QUIDENS BLVD BRIARWOOD, NY MRI Lumbar spine x 0 72148 \$1,003.20  TOTAL CHARGES TO DATE: \$1,970.90  1/12/24 136-21 QUIDENS BLVD BRIARWOOD, NY MRI Lumbar spine x 0 72148 \$1,003.20  1/12/24 136-21 QUIDENS BLVD BRIARWOOD, NY MRI Lumbar spine x 0 72148 \$1,003.20  1/12/24 136-21 QUIDENS BLVD BRIARWOOD, NY MRI Lumbar spine x 0 72148 \$1,003.20  1/12/24 136-21 QUIDENS BLVD BRIARWOOD, NY MRI Lumbar spine x 0 72148 \$1,003.20  1/12/24 136-21 QUIDENS BLVD BRIARWOOD, NY MRI LUMBAR SPINE LUMBAR SPINE LUMBAR SPINE X 1,003.20  1/12/24 136-21 QUIDENS BLVD BRIARWOOD, NY MRI LUMBAR SPINE LUMBAR SPIN	14. WILL TH ACCIDENT	?		LITATION AND/OR OCC		HERAPY AS A See doct			RIES SU	STAINED IN THIS
SERVICE  INCLUDING ZIP CODE  INCLUDING ZIP COD	15. REPOR	T OF SERVICES RE	NDERED -	ATTACH ADDITIONAL	SHEETS IF NE	CESSARY				
1/12/74   11-23   11		the state of the seal of the state of the st	1						- 1	TOTAL CHARGE
1/12/24  136-11 QUEDES SILVD BRIARWOOD, NV MRI Lumbar spine  x 0 72148  \$1,970.90  TOTAL CHARGES TO DATE: \$1,970.90  16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING. Treating Provider's Name Title License or Certificate No. Business Relation (check applicable box) David Borukhov Radiologist 270938  17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL ICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary). David Borukhov Radiologist 270938  18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES X NO  19. ESTIMATE DURATION OF FUTURE TREATMENT: Not determined at this time  PATIENT: Your health provider may agree to accept for health services performed directly from your insurer(Authorizzation to Pay Benefits) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and healthy provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form. 20(F YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN 21]. Lauthorize payment of health benefits to the undersigned health ace provider or supplier of services described below. I retain all rights, privileg and remedies to which I am entitled under Article 51 (The No-Fault provision) of the insurance law.  PRINT NAME Patient Patient Patient Patient Patient Patient Patient Date  PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (Assignment of Benefits). If you and your health provider agree to an assignment of benefits, you must both sign the patient of the prescribed Ni-A-NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFI	1/12/24		RIARWOOD, NY	MRI Cervical spine		•	x 0	72141	'	\$967.70
16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING: Treating Provider's Name Tide License or Certificate No. Business Relation (check applicable box)  David Borukhov Radiologist 270938	1/12/24	138-21 QUEENS BLVD BR	RIARWOOD, NY	MRI Lumbar spine	:		x 0	72148		\$1,003.20
Treating Provider's Name Title Licence or Certificate No. Employee Independent Contractor Other (speedly) David Borukhov Radiologist 270938										\$1,970.90
David Borukhov Radiologist 270938 Employee Independent Contractor Other (specify)  17, FTHE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).  18, IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?  19, ESTIMATE DURATION OF FUTURE TREATMENT:  Not determined at this time  PATIENT: Your health provider may agree to accept for health services performed directly from your insure(Authorization to—Pay Benefits) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below by checking off the designated spot in time 20 of this form.  20. (If YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21 I authorize payment of health benefits to the undersigned health care provider or supplier of services described below. I retain all rights, privileg and remedies to which I am entitled under Article 51 (The No-Fault provision) of the insurance law.  PRINT NAME Patient Date  Patient Date Signature on File  Patient Date  Patient Date Signature on File  Patient Date  Patient Date Provider of Health Care Service (Assi			IS DIFFERE	NT THAN BILLING PRO	VIDER COMPL	ETE THE FOL	LOWING	S:		
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PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (Assignment of Benefits). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in #21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.  21. X (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)  I hereby assign to the health care provider indicated below all right, privileges and remedies to payment for health care services provided by the 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, notwithstanding any other agreement 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.  PRINT-NAME	20(I ALSO ENT	IF YOU HAVE CHOS TER INTO AN ASSIGN E payment of health	SEN TO AUT SNMENT OF benefits to t	HORIZE THE DIRECT BENEFITS CONTAINE he undersigned health c	PAYMENT OF D IN #21) are provider or	supplier of se	rvices de			
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provider (Assignment of Benefits). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in #21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.  21X(IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)  I hereby assign to the health care provider indicated below all right, privileges and remedies to payment for health care services provided by the 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, notwithstanding any other agreement 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.  PRINT NAMELOPEZ_VARGAS_SILVANA_LUCERO		Pa	tient				Pati	ent		Date
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	PRINT NA			Care Service (Assignee)	-	SIGNED	Prov			Date.
Is the original signature of the parties on file?  X Yes No	Has an or	riginal authorizati	on or assig	nment previously bee	en executed?	. <u>x</u>	Yes	3		No
	Is the orig	inal signature of the	parties on f	île?	•	X	Yes	<b>S</b>		No