PATIENT'S NAME : BOLIVAR URREGO DIANA INVOICE NUMBER 0010448

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

X YES ____ NO If 'YES', describe your recommendation below: See doctor's report

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICES RENDERED	FEE SCHEDULE TREATMENT CODES	TOTAL CHARGE
6/29/23	138-21 QUEENS BLVD BRIARWOOD, NY	MRI Knee Left	73721	**$966.54**
6/29/23	138-21 QUEENS BLVD BRIARWOOD, NY	MRI Shoulder Left	73221	**$966.54**
			TOTAL CHARGES TO DATE :	**$1,933.08**

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

Treating Provider's Name	Title	Licence or Certificate No.	Business Relation (check applicable box)		
			Employee	Independent Contractor	Other (specify)
David Borukhov	Radiologist	270938			Owner

17. IF THE 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).

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 **(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 healyh provider. You may use the optional authorization language provided below, by checking off the designated spot in item 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, privileges and remedies to which I am entitled under Article 51 (The No-Fault provision) of the insurance law.

PRINT NAME _____ SIGNED _____

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 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 BOLIVAR URREGO DIANA SIGNED Signature on File

Patient (Assignor) Patient Date

PRINT NAME David Borukhov SIGNED Signature on File

Provider of Health Care Service (Assignee) Provider of Health Care Service Date

Has an original authorization or assignment previously been executed? [X] Yes [ ] No

Is the original signature of the parties on file? [X] Yes [ ] No

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 MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,