# GENERAL CONSENT

This document applies to the following individuals who and entities that provide care to you: (1) clinical affiliates of Dr. Scott Selby, LLC and (2) Independent undergraduate student interns of the Applied Health Science department of Wheaton College who work under the supervision of Dr. Scott Selby

## I. GENERAL CONSENTS AND ACKNOWLEDGMENTS

**CONSENT FOR DIAGNOSIS, CARE AND TREATMENT**. I consent to diagnosis, care and treatment that I have agreed to receive and that is considered necessary or advisable by my physicians(s), including my attending chiropractic physician, Dr. Scott Selby and other healthcare professionals who may be involved in my care, Dr. Scott Selby LLC employees and agents. I acknowledge that no guarantees have been made to me about the result of my examination or treatment at or by any Dr. Scott Selby LLC affiliate or independent physician.

**ACKNOWLEDGMENT OF EDUCATIONAL AND RESEARCH MISSIONS.** Dr. Scott Selby LLC clinical affiliates share a common mission of excellence in patient care, research and education in collaboration with Wheaton College Sports Medicine and Wheaton College Applied Health Science. I understand that my care may be provided in a teaching environment and that undergraduate health science interns in training may be involved in my care and treatment. I also understand that my health information may be used within the Wheaton College educational system and released outside Dr. Scott Selby LLC for research purposes in accordance with law and the Dr. Scott Selby Notice of Privacy Practices.

I understand that the Dr. Scott Selby, LLC clinical affiliates record medical and other information related to my diagnosis, care and treatment (referred to as “my health information”) in electronic, video, photographic, audio and other forms. I consent to production and internal use by the Dr. Scott Selby, LLC clinical affiliates of any videotape, photographs, audio records and other images containing my health information for education and for healthcare operations as defined in the Dr. Scott Selby, LLC Notice of Privacy Practices.

**TREATMENT AND CONTINUITY OF CARE. As applicable,** and when my consent is required by law, I consent to Dr Scott Selby LLC clinical affiliates’ contacting or sharing my health information with other healthcare providers, such as Athletic Trainers, Physical Therapists, Independent Physicians, physicians not on staff with Dr. Scott Selby, LLC, other hospitals, nursing homes, home health agencies, and pharmacies, to obtain information about my prior and current health conditions as is necessary for treatment, continuity of care and discharge planning purposes

I HAVE READ and fully agree to each of the statements in this form and sign below as my free and voluntary act. Dr. Scott Selby LLC will not be bound by any changes I make to this document. Except for services that I receive on an emergency basis, I understand that if I refuse to sign this document as presented, the Dr. Scott Selby, LLC clinical affiliates may not be able to provide services to me.

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Signature of Patient or Legally Authorized Representative  Date of Signature

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Relationship of Legally Authorized Representative to Patient

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Witness Signature  Date of Signature