*Pathways to Health, L.L.C.*

*Consent to Treatment Form with Massage/Craniosacral Therapy*

By signing below, I hereby voluntarily consent to be treated with massage and/or Craniosacral therapy from a certified massage therapist. I understand that the massage therapist practicing in the state of Virginia is not a primary care provider and that regular primary care by a licensed physician is an important choice that is strongly recommended by us. Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless Marcus Walther from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

**Massage/bodywork:** I understand that the massage/bodywork I receive is provided for the basic purposes of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should seek a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there will be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

**Craniosacral Therapy:** I understand that craniosacral therapy is a light-touch manual therapy that addresses restrictions in the craniosacral system-the membranes and fluid that surround and protect the brain and spinal cord. These restrictions could cause any number of sensory, motor, or neurological disabilities. This vital system extends from the bones of the skull, face, mouth, which make up the cranium, down to the sacrum, or tailbone area. This procedure is performed on a fully clothed body. Using a light touch - generally no more than the weight of a nickel - the practitioner monitors the rhythm of the craniosacral system to detect potential restrictions and imbalances. The therapist then uses delicate manual techniques to release those problem areas and relieve undue pressure on the brain and spinal cord. This results in a central nervous system free of restrictions, and a body that's able to return to its greatest levels of performance.

**Client's Signature Date**

**Client's Printed Name**

**Address**

**City State Phone**

**Practitioner's Signature Date**

**Consent to Treatment of Minor:** By my signature below, I hereby authorize practitioners to administer massage, bodywork, somatic therapy techniques and/or craniosacral therapy to my child or dependent as they deem necessary.

**Printed Child's Name DOB**

**Signature of Parent or Guardian Date**

**Printed Name of Parent or Guardian**