PATIENT RELEASE AND CONSENT TO TREATMENT

I, _____, hereby request and consent to Craniosacral therapy from Maggie Grucci, M.A. CCC-SLP, CST-T.

___I understand that my treatment may require the provision of varied therapies including, but not limited to CranioSacral Therapy®, therapeutic exercises, therapeutic activities, manual therapy, instrument-assisted soft tissue mobilization, yoga therapy and education. I realize that the particular therapeutic outcomes of these treatments, individually and jointly, cannot be predicted with certainty and no guarantee is made regarding any particular result or outcome.

___I consent to the procedures that may be performed during this outpatient episode of care rendered as provided by the Provider, Maggie Grucci Craniosacral therapy.

___I understand and will report to Maggie Grucci Craniosacral therapy any history with the following conditions as they may be medically contraindicated for receiving Craniosacral therapy and I have discussed this with my medical physician before consenting to receiving craniosacral therapy treatment:

- RECENT CONCUSSION
- CEREBRAL SWELLING
- STRUCTURAL DEFICITS IN THE CEREBELLUM SUCH AS ARNOLD-CHIARI MALFORMATION
- EHLERS-DANLOS SYNDROME
- BRAIN ANEURYSM
- TRAUMATIC BRAIN INJURY
- BLOOD CLOTS
- ANY DISORDER THAT CAUSES INSTABILITY IN OF CEREBRAL FLUID PRESSURE, FLOW, OR BUILD UP.

___I understand that Medicare will not pay for Craniosacral therapy. Maggie Grucci Craniosacral Therapy is not a provider under Medicare or Medicaid benefits. By signing below, I accept fully and without restriction that I am responsible for 100% of charges and will not make attempts to receive reimbursement through my Medicare or any other private health insurance benefits due to the above stated reasons.

___I do hereby release, forever discharge, and waive Maggie Grucci Craniosacral Therapy from claims and causes of action of any kind whatsoever.

___I also understand, release, and waive any liability from *Thrive Therapeutics Asheville*, current location of Maggie Grucci Craniosacral Therapy, of any responsibility or involvement in my current treatment services.

Client Signature_____ Date_____