Reverza Aesthetic Medicine

PLATELET RICH PLASMA (PRP) INFORMED CONSENT

I have been advised and consulted about the injection technique of platelet rich plasma to my (please check)
____ face ____ neck

I have been advised that platelet rich plasma is a procedure that can be used to improve hair thickness and improve the appearance of facial wrinkles. It may require multiple treatments to obtain the desired results. The effect is not long-lasting and may need subsequent treatments.

I agree to adhere to all safety precautions and instructions after the treatment. I understand that medicine is not an exact science and acknowledge that no guarantee has been given or implied by anyone as to the results that may be obtained by this treatment.

I understand this procedure is “elective” and not covered by insurance and that payment is my responsibility. Any expenses which may be incurred for medical care I elect to receive outside of this office, such as, but not limited to dissatisfaction of my treatment outcome will be my sole financial responsibility. Payment in full for all treatments is required at the time of service and is non-refundable.

I hereby give my voluntary consent to this PRP procedure and release Reverza LLC and Dr. Asirot from liability associated with the procedure. I certify that I am a competent adult of at least 21 years of age. I understand that if I have questions or concerns regarding my treatment, I will notify the office so that timely follow-up and intervention can be provided.

The technique requires the injection of Platelet Rich Plasma derived from my own blood according to standard blood collection and injection techniques.

The procedure may initially increase the painful area or reproduce symptoms for one to three days (and occasionally, as long as ten days), and then may decrease in intensity, but may not completely eliminate my symptoms.

I have been informed of the alternatives to PRP.

I have been informed that the risks and complications of PRP are immediate pain at the injection site, bruising, allergic reaction, infection, nerve or muscle injury, dizziness or fainting, bleeding, itching at injection site.

I have read or have read to me the above consent. The procedure was explained to me. I understand that I am entitled to a copy of this consent upon request.

I understand that this procedure is usually not covered by insurance and I am responsible for the total charges.

____ __________________
Patient Signature Date

____ __________________
Witness Date