REVERZA Aesthetic Medicine

Platelet Rich Plasma (PRP) Treatment for Hair Loss Informed Consent

Platelet Rich Plasma (PRP) is an injection treatment that uses the components of a person's own blood to stimulate hair growth. It requires multiple treatments in combination with other modalities to have satisfactory and significant results.

Relative Contraindications

- Certain skin diseases (i.e. SLE, porphyria)
- Allergies to some anesthetics
- Cancers
- Chemotherapy
- Certain blood or bleeding disorders
- Anti-coagulation therapy
- Chronic liver disease
- Systemic use of corticosteroids within two weeks of the procedure

Risks and Complications

- Pain or itching at the injection site
- Bleeding, bruising, swelling and/or infection
- Temporary pinkness/redness (flushing) of the skin
- Allergic reactions to the solution
- Injury to a nerve from the injection
- Nausea
- Peri-operative dizziness or fainting

Photographs

I authorize the taking of clinical photographs for historical, training, and/or promotional purposes. I understand confidentiality will be maintained.

Consent

My consent and authorization for this elective procedure is strictly voluntary. By signing this informed consent form, I hereby grant authority to **Dr. Asirot** to perform Platelet Rich Plasma (PRP) injections to area (s) discussed during our consultation.

I have read this informed consent and certify I understand its contents in full. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement.

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. In the event the patient purchase a package of treatment at a discounted rate, should the patient cancel the rest of the treatments, patient will be refunded the remainder of the amount taking into account that the price of treatment that has been done is not discounted.

I hereby give my voluntary consent to this PRP procedure and release Reverza and its staff 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 this office at 541-6004569 so that timely follow-up and intervention can be provided.

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Patient Name (print) Patient Signature/Date

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Physician Name (print) Signature/Date