Neighborhood Medical Center

5917 Belt Line Rd Dallas TX 75254

CONSENT FOR PRP INJECTION PROCEDURE

DATE: ________________________________

1.I, ______________________________, hereby give consent to ____________________ **Neighborhood Medical Center** and its assistants to perform a PRP injection procedure. I also consent to any other medical services during the procedure that may become medically reasonable and necessary. This includes, but is not limited to, the administration of anesthetics necessary to perform PRP injections.

2.I have declared that I have allergies to :_________________________________

3.I have declared that I take the follow medications:

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4. I understand that PRP can be used to treat hair loss. I fully understand the results that I may reasonably expect. I understand that not all patients get improvement.

5. I declare I do not have any of the following conditions which might otherwise not make me a candidate:

Current infections Skin diseases such as lupus or porphyria

Current cancer Current chemotherapy treatments

Severe metabolic or systemic disorders Liver disease

Abnormal platelet function (blood disorders) Anticoagulation therapy

Current use of corticosteroids Steroid injections in my scalp in the last month

6. An explanation of the procedure has been given to me. I understand that blood will be drawn from a vein in my arm. That blood will then be placed in a PRP machine to be spun down in order to concentrate the platelets and then injected back into my scalp. I understand the local freezing medications will be given to reduce discomfort of the PRP injections

7.I am aware of the pros, cons and alternatives to PRP injections. I have the option of doing nothing, wearing a wig or hairpiece, using prescription medicines or possibly having a hair transplant surgery. A combination of the above is also possible. I understand that the PRP injection procedure is an “elective” procedure. If I do not have PRP injections, I will not experience harm or negative consequences for my body other than potentially lose more hair.

8. I agree that the procedure recommended by Neighborhood Medical Center are the best recommendations at the time of consultation, consistent with my current level of hair loss. I agree these recommendations may later need to be modified depending on future developments in my hair loss, changes in my own goals or technology.

9.I understand that hair loss is sometimes continuous throughout life for some people. I understand that additional PRP injection procedures may be needed and that some individuals would expect 1-3 sessions per year.

SIDE EFFECTS

i. Minor discomfort (pin prick senation) from blood draw

ii. Dizziness and feeling faint (rare)

iii. A temporary headache

iv. Redness in the scalp for 2-4 days

v. Swelling in the forehead and around the eyes. There may rarely be swelling discoloration and bruising associated with the procedure.

vi. Reaction to local freezing medications

vii. Hair loss (temporary) in the existing hair. This is often termed ‘shock loss.’

viii. Infection (very rare)

ix. Itching at the injection sites

x. Minor bleeding and bruising at the sites of injections

xi. Injury to nerve during blood draw (very rare)

I have read and understand all of the possible side effects and complications listed above. I accept the risks of these possible complications and consequences associated with this surgery.

__________________________________ __________________________________

Patient Signature Date Provider Signature Date

10. I consent to and authorize the performance of PRP Injections by a provider at Neighborhood Medical Center, its nurses , its medical assistants and technicians. In understand that in some cases, Neighborhood Medical Center has other doctors or providers who observe for the purpose of advancing medical knowledge and teaching. I authorize these individuals to be present during my procedure and have the right to state if I do not want such learners present in line 19 below.

11. I consent to having my photos taken. These include prei operative (‘before’) photos, photos during the procedure (‘during’) and posti operative (‘after’) photos. I understand these photos will not reveal my identity. I give consent to Neighborhood Medical Center to use these photos in teaching and research, including teaching of doctors, students, trainees and the general public. I consent to having photos used for advertising purposes, which may include brochures, websites and use during prei operative consultations. I understand that I may withdraw consent by stating ‘no consent for sharing photos’ on line 19 below. However, photos will still be obtained for my chart and for purposes of documentation of surgical outcomes.

12. I believe that I have been well informed. I understand that good results are expected, but the practices of medicine and surgery are not exact sciences. I understand that knowledgeable practitioners sometimes disagree as to the best methods of treatment to achieve desired results.

13. I understand that the success of the PRP procedure is dependent on my closely following all instructions. This includes but is not limited to, prei operative and posti operative activities and precautions. I understand how to contact Neighborhood Medical Center should I have any concerns 7 days per week. I

14. This consent was read and signed while I was not under the influence of medications that might alter my mental capacity to understand its contents.

15. I certify this form has been read or it has been read to me, the blank spaces have been filled in, and I understand its contents. I was given the opportunity to ask questions about PRP.

16. I have disclosed all information regarding past and present medical conditions, current medications and known drug allergies. This information is necessary so that the proper medical treatment is given at all times during the transplant procedure.

17. This procedure is offered to obtain the best results for the patient, separate of any profit motive. I am aware that the practice of medicine and surgery is not an exact science and that knowledgeable physicians sometimes disagree as to best methods of treatment to achieve desired results. I certify that no one has made any guarantee or warranty as to the final outcome or appearance that may be expected.

18. I acknowledge that I am responsible for payment of these services with no fee reimbursement regardless of procedure results. I understand the fee paid is for the procedure and not for an expected result. I understand that payment is due the day of my procedure.

19. I have been given the opportunity by my physician to ask questions and all of my questions have been answered to my satisfaction. I impose the following limitations on my treatment:

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DATE: _________________________________

TIME: _________________________ (am or pm)

I have read the above information and am aware of the risks, benefits and alternatives of PRP therapy. I have been provided with the opportunity to have questions answered and therefor give my consent to PRP injection therapy for my hair loss.

___________________________________ ___________________________________

Signature of Patient **Date**

____________________________________ _____________________________________

Signature of Provider **Date**

I certify that on this date I have observed the patient carefully read an sign this consent form of his/her own free will

____________________________________ _________________________

Signature of Neighborhood Medical Center Representative **Date**