# INFORMED CONSENT FOR MICROPEN/PRP

This treatment involves the collection of your blood (approximately 11 mL – 22 mL), then the blood is spun down using a centrifuge to separate out the plasma and platelet portion using the separator gel as a special filter. The platelet-rich plasma (PRP) portion of your blood is then used at the point of care. The product injected is 100% your own blood by product (autogous).

## CONTRAINDICATIONS

You should not have PRP treatment done if you have any of the following conditions:

- Skin conditions and diseases including: Facial cancer, existing or uncured. This includes SCC, BCC and melanoma, systemic cancer, chemotherapy. Steroid therapy, dermatological diseases affecting the face (i.e. porphyria, active acne, eczema, psoriasis or rosacea), communicable diseases, blood disorders and platelet abnormalities, anticoagulation therapy (i.e.: Warfarin).

- Platelet dysfunction syndrome, critical thrombocytopenia, autoimmune disease, Hypofibrinogenemia, hemodynamic instability, sepsis, chronic liver disease, hepatitis or any acute or chronic infections.

## PRECAUTIONS

I understand that taking any of the following medications: Aspirin, anti-inflammatory medication such as Ibuprofen, Voltaren, Diclofenac, Naproxen, Aleve, or St John's Wort supplements, or Fish Oil, Garlic, Vitamin E, Ginko, Ginseng, Ginger, or other supplements may cause bruising or bleeding. _____**(Initial)**

## PLEASE INITIAL HIGHLIGHTED AREAS

I understand this treatment may not meet my desired needs or expectations and I further understand that favorable results with PRP requires a series of 3-4 treatments spaced 4-5 weeks apart. It is my responsibility to schedule these appointments._____**(Initial)**

I consent to and authorize my provider at the healthcare facility located at **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270**, to perform this procedure with PRP (platelet-rich plasma) for aesthetic rejuvenation._____**(Initial)**

I consent to and authorize my provider at the healthcare facility located at **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270**, to take all necessary photographs before and after my procedure._____**(Initial)**

The risks and complications of the procedure include; allergic reactions to local anesthetic, infection, skin pigmentation problems, bleeding, bruising, intense pain, milia flare up, acne flare up, injury to nerves and blood vessels and other injections site reaction such as swelling, tenderness, and warmth and other unforeseen complications not described herein. _____**(Initial)**

Other alternative methods of treatment have been fully explained to me. I understand them, and I assume all responsibilities. _____**(Initial)**

All before and after care instructions have been explained and given to me. I understand my responsibility of properly following these instructions to minimize any risks of complications._____**(Initial)**

I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner and that all blanks were filled prior to my signature. _____**(Initial)**

When completing the medical questionnaire, I have answered the personal medical history questions fully and to the best of my ability. _____**(Initial)**

I understand that due to the natural variation in quality of platelet-rich plasma, results will vary between individuals. I understand that although I may notice a change after my first treatment; I may require multiple sessions to obtain my desired outcome. _____**(Initial)**

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of the treatment. I am aware that the PRP treatment is not permanent as natural degradation will occur over time._____**(Initial)**

I understand that this treatment is strictly for cosmetic purposes and will not be covered by insurance. I understand that I am responsible for all costs payable at the time of services. _____**(Initial)**

The cost of the procedure involves charges for the services provided. The total includes fees charged by **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270**, the cost of supplies and other related expenditures. Should complications develop from the procedure additional costs may occur and will be the patient's financial responsibility. Additional procedures, supplies, antibiotics, etc. will also be the patient's responsibility. _____**(Initial)**

I understand that all services that been rendered are non-refundable. _____**(Initial)**

I state that I have read (or it has been read to me), I understand this consent and I understand the information contained in it. _____**(Initial)**

By my signature below, I certify that I have read and fully understand the contents of this permission form. I was given the opportunity to have **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270** cover any question or clarification I might have prior to signing the consent and thereby grant permission to perform PRP on me by my provider at the healthcare facility located at **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270**.

Patient Name_____
Patient Signature_____ Date_____
Witness Name_____
Witness Signature_____ Date_____
Translator Name_____
Translator Signature_____Date_____
Physician Name: Art Quintanilla, MD_____
Physician Signature_____Date_____