Consent For Platelet Rich Plasma (PRP) Therapy

Purpose and Background: Platelet Rich Plasma Therapy (PRP) has been used for a number of years in orthopedics and sports medicine, to treat muscle and ligament injuries, pain problems, and skin lesions. Due to the success of PRP in medicine, the procedure was then developed into an ant-aging treatment designed to induce new collagen production, reduce wrinkles, and diminish the visible signs of aging by growing new healthy tissue. PRP is considered to be a safe, natural treatment because, rather than using a synthetic substance, it uses cells and growth factors from your own blood to slow and even reverse the aging process for a more youthful and radiant appearance. Collagen is what gives skin a firm, youthful appearance. As we age, less collagen is produced, causing sagging, wrinkles and soft tissue depressions in the skin. Once injected under the skin or applied topically onto the surface of the skin, PRP therapy counteracts aging by stimulating new collagen production in the exact areas of concern where we want the skin to repair and rejuvenate itself. PRP can be used on the face, neck, décolletage, and hands. The number of treatments needed varies per patient. We recommend 1-3 treatments administered at four-week intervals until the desired result is achieved, followed by 1-2 maintenance treatments per year. While some result is visible immediately at the time of treatment, there is usually a return to baseline in 3-5 days as the PRP is absorbed back into the body prior to the complete action of the cellular regenerative process. Most patients see improvement for up to 12 weeks with results lasting up to 2 years. If this procedure involves the use of other materials like HA Filler for the Vampire Facelift or Micro Needling for the Vampire Facial, a separate and additional consent form may be used.

Procedure: Approximately 10 cc of blood are drawn from the patient in the same way blood samples are taken for routine lab tests. The tubes of blood are put into a centrifuge, where the blood is spun in order to separate the red blood cells from the PRP. Once injected under the skin or applied topically onto the skin, the PRP releases growth factors and activates multi-potent stem cells to generate new, younger tissue. This new tissue synthesis includes new collagen for firmness and elasticity, new fatty tissue for plumpness and smoothness, and new blood vessels for a healthy rosy glow.

Please initial the following:

_____ I hereby request and authorize the use of PRP for cosmetic purposes and understand this procedure requires a simple blood draw.
_____ The details of the procedure have been explained tome in terms I understand, and I have no further questions.
_____ Alternative methods and their benefits and disadvantages have been explained to me.
_____ I understand PRP involves a series of treatments to achieve optimum results and the fee structure has been fully explained to me. The fee is for the series of treatments purchased and includes post-treatment follow-up visits. There will be a charge for additional treatments.
_____ Services purchased are non-refundable unless Holtorf Medical Group is unable to perform the treatments(s).
_____ I understand the effects of this treatment are gradual, as the healing process of platelets and growth factors stimulate a stem cell response that naturally helps collagen regenerate over time.
_____ I understand and accept the most likely risks and complications of PRP.
_____ I understand with any facial injections it is unlikely, but possible, small blood vessels could be broken which could results in temporary swelling, bruising, redness, and soreness.
_____ I have informed my technical if I have previously been injected with resorbable or permanent cosmetic fillers.
_____ I understand any injection carries a minimal but potential risk of infection.
_____ I have informed my technician of all my known allergies.
_____ I have no muscle or nerve conditions.
_____ I have not had chemotherapy or radiation treatments within the last 12 months.
_____ I have not used Accutane (isotretinoin) in the past 12 months.
_____ I am not currently pregnant or breastfeeding.

Consent For Platelet Rich Plasma (PRP) Therapy (cont.)

_____ I have truthfully and accurately disclosed all personal medical history information including, but not limited to, all previous aesthetic procedures and invasive medical procedures. I understand that failure to do so may negatively affect my treatment outcome.

_____ I understand that elective aesthetic procedures should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of.

_____ I have informed my technician of all medications I am currently taking including prescriptions, over the counter remedies, herbal therapies, and any others.

_____ I have been advised whether I should take any or all of the medications on the days surrounding my procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made or implied.

_____ I have been informed off what to expect post-treatment, including, but not limited to procedures, if I wish to maintain the appearance this procedure provides me.

_____ I understand and agree that photographs will be taken before and after each procedure(s). and are considered a confidential and essential component of my medical record. The photographs will not be used for or disclosed for any media purposes without my signed permission on a separate media consent form.

_____ I release all Holtorf Medical Group staff from liability associated with this procedure except for any liability that may be imposed by the laws of the state of California.

_____ In the case of any dispute, I agree to make a good faith effort to resolve the matter directly with Holtorf Medical Group. If the matter cannot be resolved directly with Holtorf Medical Group I agree to forego litigation and submit to binding arbitration in the state of California.

Patient Name (print): _____ Date: _____

Patient/Guardian Signature: _____

Provider Name (print): _____ Date: _____

Provider Signature: _____