**PRP/PRF Treatment Consent**

Platelet rich plasma (PRP) and platelet rich fibrin (PRF) are an injection treatment that uses the components of a person's own blood to stimulate hair growth. Platelets are very small cells in your blood that are involved in the clotting process. When PRP/PRF is injected into the damaged area it causes a mild inflammation that triggers the healing cascade. As the platelets organize in the tissue, they release a number of enzymes to promote healing and restoration of tissue. They also have been shown to promote hair growth.

A small quantity of blood (25-55cc) is drawn from the patient. This is relatively small amount compared to blood donation which removes approximately 500cc. The blood is spun in a special centrifuge (according to standard Harvest Techniques) to separate its components (red blood cells, platelet rich plasma and plasma). The platelet rich plasma/fibrin is separated from the rest of the blood. It may then be activated with small amount of calcium to allow the release of growth factors from the platelets which in turn amplifies the healing process. Following the administration of local anesthesia (lidocaine), PRP/PRF is then injected directly into the treatment area.

Relative contraindications; acute and chronic infections, certain skin diseases (SLE, porphyria etc.), allergies to anesthetics (lidocaine, bupivacaine), cancer, chemotherapy, blood or bleeding disorders, anti-coagulation therapy, chronic liver disease, systemic corticosteroid therapy within 2 weeks of the treatment and pregnancy.

Risks and complications (these are the potential ones but are not limited to); pain, itching at injection sites, bleeding, bruising, swelling, infection, temporary redness or flushing of skin, allergic reaction to components of therapy, injury to nerves, nausea, vomiting, dizziness and or fainting.

Consent: my consent and authorization for this elective procedure is strictly voluntary. By signing this informed consent form, I hereby grant authority to the provider, Brandy Tafoya, APRN-C, to perform PRP/PRF injections to area(s) discussed during our consultation. I have read this informed consent and certify I understand the contents in full.

Al 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 including unforeseen adverse outcomes from therapy. Payment in full for all treatment is required at the time of service and is non-refundable.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Text, letter

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Provider Signature: