INFORMED CONSENT

My physician or properly licensed medical professional has informed me that this procedure, based on current medical evidence, is appropriate for my condition, though there can be no guarantee that the treatment will be effective or that my condition will improve. **This procedure/treatment utilizes FDA cleared equipment** but mesenchymal stem cells to be produced and stored by Akan Biosciences, LLC are not to be used for procedures in the United States unless under the supervision of an FDA approved study.

BENEFITS AND ALTERNATIVES OF TREATMENT. My physician or properly licensed medical professional has fully explained to me the nature and the purpose of this treatment. My physician has explained how this treatment may benefit me or my family.

RISKS. My physician or properly licensed medical professional has explained that this treatment must be performed by a physician or properly licensed medical professional. My physician or properly licensed medical professional has told me that there are potential risks and complications, from both known and unknown causes, that could reasonably be possible. Included in our discussion were the following risks:

- Some patients may experience local reactions at the site of treatment including inflammation
- Infection
- There is a small risk of hypersensitivity (allergic) reactions
- There is a risk my adipose lipoaspirate after lab validation may not qualify for use or yield less mesenchymal stem cells than desired.
- Akan Biosciences, LLC is not responsible for Physician or medical professional error
- Additional risks discussed: _____
  _____.

WITHDRAWAL OF CONSENT. I understand that I am free to withdraw this consent and to discontinue this procedure prior to procedure.

NO GUARANTEES. I acknowledge that no guarantees or assurances have been made to me concerning this procedure.

FINANCIAL RESPONSIBILITY. I also acknowledge that I have been informed that my health insurance or other health care benefit plan likely will not cover this procedure. Nonetheless, I wish to have the procedure, and understand that I will have to pay for this procedure myself. I understand that the Practice will not submit a claim and will not be responsible if the claim is denied.

UNDERSTANDING OF THIS FORM. I acknowledge that I have read this document in its entirety and that I fully understand it and that all blank spaces have been either completed or crossed off prior to my signing.

_____ _____

Patient's Signature Date

_____ _____

Witness Signature Date