INFORMED CONSENT FOR PRP (Platelet Rich Plasma) TREATMENT

I hereby request a PRP treatment by Kaado MD. have read, understand, and agree to the following:

READ CAREFULLY AND INITIAL BEFORE PROCEEDING

Platelet Rich Plasma, or also known as "PRP" is an injection treatment whereby a person's own blood is used. A fraction of blood (20cc-55cc) is drawn from the individual patient into a syringe. This is a relatively small amount compared to blood donation which removes 500cc. The blood is spun down 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 is first separated then activated with a small amount of calcium to allow the release of growth factors from the platelets which in turn amplifies the healing process.

PRP is then applied topically or injected into the area to be treated. Platelets are very small cells in your blood that are involved in the clotting process. When PRP is injected into the damaged area it causes a mild inflammation that triggers the healing cascade. As the platelets organize in the clot, they release a number of enzymes to promote healing and tissue responses including attracting stem cells to repair the damaged area. As a result, new collagen begins to develop. As the collagen matures, it begins to shrink causing the tightening and strengthening of the damaged area. When treating injured or sun and time damaged tissue, they can induce a remodeling of the tissue to a healthier and younger state.

The full procedure takes approximately 45 minutes - 1 hr. Generally 2-3 treatments are advised, however, more may be indicated for some individuals. Touch up treatment may be done once a year after the initial group of treatments to boost and maintain the results.

Along with the benefit of using your own tissue and therefore eliminating allergies, there is the added intrigue of mobilizing your own stem cells for your benefit. PRP has been shown to have overall rejuvenating effects on the skin such as improving skin texture, fine lines and wrinkles, increasing volume via the increased production of collagen and elastin, and by diminishing and improving the appearance of scars. Other benefits include minimal down time, safe with minimal risk, short recovery time, natural looking results, and no general anesthesia is required.

The treatment may require a local anesthetic (topical cream and/or injection) and/or oral sedation. This decision will be based on the treatment parameters and is at the physician's discretion.

It is recommended that you not take aspirin, allergy or cold medication, muscle relaxants, sleep medication, non-steroidal anti-inflammatory medication, or any blood anti-coagulants before this procedure. These medications may increase the risk of bruising. If you can stop these medications, you should do so one (1) week before the procedure.

I understand that PRP may be used in non-FDA approved areas, and I consent to the application of PRP in those non-FDA approved areas.

PRP is safe for most individuals between the ages of 25 – 80. It contraindicated for individuals with the following conditions: acute and chronic infections; skin diseases; cancer; chemotherapy; severe metabolic and systemic disorders; abnormal platelet function or blood disorders; chronic liver disease; undergoing anti coagulation therapy; underlying sepsis; systemic use of corticosteroids within 2 weeks of the treatment; pregnant or breastfeeding. **I certify that I am free of these conditions.**

POTENTIAL RISKS AND SIDE EFFECTS

Side effects may include pain or itching at the injection site; bleeding, bruising, swelling and/or infection; short lasting pinkness/redness (flushing) of the skin; allergic reaction to the solution; injury to a nerve and/or muscle; nausea/vomiting; dizziness or fainting; temporary blood sugar increase.

I understand the importance of the pre and post treatment instructions and that the failure to comply with these instructions may increase the possibility of complications.

I have discussed the nature of my condition, the recommended medical procedure, the general nature of the proposed treatment, reasonable therapeutic alternatives to the treatment, and the risks of such alternatives. My physician has discussed the common problems or risks. **I am advised good results are expected**, but the possibility and nature of complications cannot be accurately anticipated and therefore, **no guarantee has been expressed or implied** as to the success or other result of treatment. I have had the opportunity to ask questions, which have been answered to my satisfaction. I understand the procedure and its side effects.

BEFORE AND AFTER TREATMENT

Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.

PHOTOGRAPHS

I give permission for photographs to be taken of all sites treated, which will be used to document my medical record. I also give permission for the photographs taken to be used for illustrations of scientific papers or use in educational/training lectures and select marketing materials. I understand my name shall not be used in any publication.

MEDICAL HISTORY

I have informed the doctor of all my known allergies and all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, antiplatelet or anticoagulation

medications. I have been advised about which of these medications I should avoid taking on the days surrounding the procedure.

I understand Fouad Georges Kaado Moawad, M.D., or another trained staff member under Dr. Kaado's supervision, will provide my treatment. The treatment provider will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I have provided and agree to continue to provide accurate and complete information about my medical history and conditions. I herein state that I am not pregnant or nursing.

FOLLOW-UP TREATMENT

I agree to follow up with Kaado MD at the recommended intervals at the Kaado MD office location and to contact Kaado MD and advise of any change in my condition, medical history or any problem I may experience. I agree to contact Kaado MD immediately should any unusual side effects occur. I understand that in case of a medical emergency, I should call 911 or go to an emergency medical facility.

PAYMENT

I certify that I am aware of and accept the fees and charges for the treatment, and agree that I am solely responsible for payment to Kaado MD.

INFORMED CONSENT

By signing this **INFORMED CONSENT,** I hereby acknowledge:

1. I have read or had this Consent Form read and/or explained to me.
2. I fully understand and agree to the contents of this Consent Form.
3. I have been given ample opportunity to ask questions regarding this treatment and all questions have been answered to my satisfaction.
4. I understand that there are inherent risks, side effects and potential complications of this treatment, as described in this consent form.
5. No guarantees have been made concerning the results nor the outcome of this procedure.
6. This document constitutes the full disclosure and supersedes any previous verbal or written disclosures, or any advertising or marketing materials prepared by Kaado MD or others.
7. It is understood that Kaado MD only provides specialty services and is not responsible for my comprehensive medical care.

I hereby voluntarily request and give my consent for Kaado MD to perform the procedure described herein, the PRP Treatment as requested. My consent includes all follow up or repeated treatments as recommended by Kaado MD.

THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING

Client Name (Printed): _____

Client Signature: _____ Date: _____