

# CLIENT CONSENT FORM

## PLATELET-RICH PLASMA THERAPY



Please read and **initial** each statement.

I have read the pre and post treatment instruction sheets and have had the opportunity to ask questions about the treatment. \_\_\_\_\_

I authorized Hair Loss Solutions to do PRP treatment on me. \_\_\_\_\_

***I understand:***

- That I will lower the success of the treatment if I do not follow pre and post care instructions. \_\_\_\_\_
- That there is an increased risk of side effects if I do not follow pre and post care instructions. **The most common side effects are discomfort, pinpoint bleeding and minor bruising.** There may be risks not yet known at this time. \_\_\_\_\_
- That most issues require multiple PRP sessions approximately one month apart. Results may wear off if not maintained. Results vary between individuals. Some people exceed our expectations and some people respond below expectations. Although good results are expected, with the focus on improvement and not perfection, every person is unique, and it is impossible to guarantee results. If you have no results from your treatments or decide to cancel your treatments, you will not receive a refund. \_\_\_\_\_
- That a treatment series is a minimum of four treatments: one month to six weeks apart. Maintenance treatment is recommended every 9 to 12 months. \_\_\_\_\_
- That the risk of side effects or decreased/lack of response to treatment may increase with certain medical conditions such as immunocompromised conditions (HIV, lupus, RA, colitis, being on immune suppressants such as prednisone), under-controlled medical conditions (eg diabetes), smoking, blood disorders and with the use of certain medications that increase the risk of bleeding (aspirin, coumadin, Plavix, vitamin E, various herbal product, ibuprofen and other non-steroidal anti-inflammatories) or a history of anaphylaxis. PRP treatments are contraindicated for pregnant or breastfeeding women. None of these conditions apply to me or if they do I am aware of the increased risk. \_\_\_\_\_
- I am aware that there may be other options for treatment including not having the procedure. \_\_\_\_\_

I have read and understand this **Platelet-Rich Plasma Treatment Consent Form**. My questions have been answered satisfactorily. I accept the risks and complications of the procedure.

\_\_\_\_\_  
Client Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature