BEAUTOX BAR

INFORMED CONSENT FOR PRP INJECTION TREATMENT

Patient Name _____
Date: _____

1. I, _____ [Patient Name] hereby give consent to Beautox Bar LLC to perform a Platelet-rich plasma ("PRP") injection treatment. I also consent to any other healthcare services during the procedure that may become medically reasonable and necessary within the reasonable judgement of a healthcare professional. This includes, but is not limited to, the administration of anesthetics necessary to perform PRP injections.

2. I have declared that I have allergies on my health history intake form.

3. I have declared that I take the follow medications on my health history intake form.

4. I understand that PRP can be used to treat hair loss. I fully understand the results that I may reasonably expect. I understand that not all patients get improvement.

5. I declare I do not have any of the following conditions which might otherwise not make me a candidate: Current infections, Skin diseases such as lupus or porphyria, Current cancer, Current chemotherapy treatments, Severe metabolic or systemic disorders, Liver disease, Abnormal platelet function (blood disorders), Anticoagulation therapy, Current use of corticosteroids, Steroid injections in my scalp in the last month.

6. An explanation of the procedure has been given to me. I understand that blood will be drawn from a vein in my arm. That blood will then be placed in a PRP machine to be spun down in order to concentrate the platelets and then injected back into my scalp. I understand the local freezing medications will be given to reduce discomfort of the PRP injections.

7. I am aware of the pros, cons and alternatives to PRP injections. I have the option of doing nothing, wearing a wig or hairpiece, using prescription medicines or possibly having a hair transplant surgery. A combination of the above is also possible. I understand that the PRP injection procedure is an "elective" procedure. If I do not have PRP injections, I will not experience harm or negative consequences for my body other than potentially losing more hair.

8. I understand that hair loss is sometimes continuous throughout life for some people. I understand that additional PRP injection procedures may be needed and that some individuals would expect 1-3 sessions per year.

SIDE EFFECTS
i. Minor discomfort (pin prick sensation) from blood draw
ii. Dizziness and feeling faint (rare)
iii. A temporary headache
iv. Redness in the scalp for 2-4 days
v. Swelling in the forehead and around the eyes. There may rarely be swelling discoloration and bruising associated with the procedure.

vi. Reaction to local freezing medications
vii. Hair loss (temporary) in the existing hair. This is often termed ‘shock loss.’
viii. Infection (very rare)
ix. Itching at the injection sites
x. Minor bleeding and bruising at the sites of injections
xi. Injury to nerve during blood draw (very rare)

I have read and understand all of the possible side effects and complications listed above.
I accept the risks of these possible side effects associated with this procedure.

_____ _____
Patient Signature Date

9. I consent to and authorize the performance of PRP Injections by Beautox Bar LLC’s Registered Nurses.

10. I consent to having my photos taken. These include pre-operative (‘before’) photos, photos during the procedure (‘during’) and post-operative (‘after’) photos. I understand these photos will not reveal my identity. I give consent to Beautox Bar LLC to use these photos for advertising purposes, which may include brochures, websites and use during preoperative consultations. I understand that I may withdraw consent by stating ‘no consent for sharing photos’ below my signature. However, photos will still be obtained for my chart and for purposes of documentation of outcomes.

11. I believe that I have been well informed. I understand that good results are expected, but the procedures are not exact sciences. I understand that knowledgeable healthcare practitioners sometimes disagree as to the best methods of treatment to achieve desired results.

12. This consent was read and signed while I was not under the influence of medications that might alter my mental capacity to understand its contents.

13. I certify this form has been read or it has been read to me, the blank spaces have been filled in, and I understand its contents. I was given the opportunity to ask questions about PRP.

14. I have disclosed all information regarding past and present medical conditions, current medications and known drug allergies. This information is necessary so that the proper medical treatment is given at all times during the procedure.

15. I acknowledge that I am responsible for payment of these services with no fee reimbursement regardless of procedure results. I understand the fee paid is for the procedure and not for an expected result. I understand that payment is due the day of my procedure.

16. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Signature of Patient Date

_____ _____