PRP and/or PepFactor for Hair Restoration Patient Consent Form

Patient Name: _____ Date: _____

Please read each paragraph and initial that you have read and understand the information.

_____I hereby give consent to Yanetsi F. Landa, MD or her designee to perform PRP and/or PepFactor for Hair Restoration injections procedure.

_____I understand 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.

_____I declare that 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
Current use of corticosteroids	Steroid injections in my scalp in the last month
Liver Disease	Anticoagulation therapy
Severe Metabolic or Systematic Disorders	Abnormal Platelet function (blood disorder)

_____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 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 lose more hair.

_____I agree that the procedures recommended by Dr. Landa Med Spa are the best recommendations at the time of consultation, consistent with my current level of hair loss. I agree these recommendations may later need to be modified depending on future developments in my hair loss, changes in my own goals or technology.

SIDE EFFECTS

- Minor discomfort (pin prick sensation) from blood draw
- Dizziness and feeling faint (rare)
- A temporary headache
- Redness in the scalp for 2-4 days
- Swelling in the forehead and around the eyes. There may rarely be swelling, discoloration, and bruising associated with the procedure
- Reaction to local numbing medication
- Hair loss (temporary) in the existing hair. This is often termed “shock loss”.
- Infection (very rare)
- Itching at the injection sites
- Minor bleeding and bruising at the sites of injections
- Injury to nerve during blood draw (very rare)

_____I understand that hair loss is sometimes continuous throughout life for some people. I understand that additional PRP injections procedures may be needed.

_____I consent to the taking of photographs prior, during, and after my treatment for the purpose of documentation/ to be used in my file and as part of our before/after case studies. If you do not want your identity known, we will ensure any pictures used to portray results are anonymous.

_____I believe that I have been well informed. I understand that good results are expected, but the practices or medicine and surgery are not exact sciences. I understand that knowledgeable practitioners sometimes disagree as to the best methods of treatment to achieve desired results.

_____I understand that the success of the PRP procedure is dependent on my closely following all instructions. This includes but is not limited to, preoperative and postoperative activities and precautions. I understand how to contact Dr. Landa Med Spa should I have any concerns.

_____I have disclosed all information regarding past and present medical conditions, current medications and known drug allergies.

_____I am aware that the practice of medicine and surgery is not an exact science and that knowledgeable physicians sometimes disagree as to the best methods of treatment to achieve desired results. I certify that no one has made any guarantee or warranty as to the final outcome or appearance that may be expected.

_____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 results. I understand the fee paid is for the procedure and not for an expected result. I understand the payment is due the date of my procedure.

_____I understand that all payments are due before my session via credit card or cash (no checks accepted) and all sales are final. No exchanges or refunds.

_____I have been given the opportunity by my physician to ask questions and all of my questions have been answered to my satisfaction. I impose the following limitations on my treatment:

_____

_____**I have read the above information and am aware of the risks, benefits, and alternatives of PRP and/or PepFactor for Hair Restoration therapy. I have been provided with the opportunity to have questions answered and therefore give my consent to PRP injection therapy for my hair loss.**

Patient Signature: _____ Date: _____

Dr. Signature: _____

Patient Signature: _____ Date: _____

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