

PROGRESSIVE MEDICAL GROUP, INC.

PRP (Platelet-Rich Plasma) Treatment – Informed Consent

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Phone: 414-251-3500 | Fax: 414-251-3504

Patient Name: _____

Date of Birth: _____

Date: _____

1. PURPOSE OF TREATMENT

I understand that Platelet-Rich Plasma (PRP) treatment involves drawing a sample of my own blood, processing the blood to concentrate platelets and other blood components, and applying or injecting the prepared PRP into the treatment area as determined by my provider.

PRP may be recommended for aesthetic or cosmetic purposes, including skin rejuvenation and improvement in the appearance and texture of the skin. Results vary from person to person and cannot be guaranteed.

I understand that PRP is not appropriate for every patient and that my provider will determine whether treatment is appropriate based on my medical history, examination, medications, skin condition, and treatment goals.

2. PROCEDURE

The procedure may include:

- Cleansing and preparation of the treatment area
- Collection of blood from a vein
- Processing of the blood using an appropriate PRP preparation system
- Application or injection of PRP into the planned treatment area
- Post-treatment skin care instructions

Local anesthetic or topical numbing may be used when appropriate.

3. POTENTIAL BENEFITS

Potential benefits may include improvement in:

- Skin texture
- Skin tone
- Overall skin appearance
- Fine lines and wrinkles
- Skin rejuvenation

I understand that individual results vary and that multiple treatments may be recommended.

4. POTENTIAL RISKS AND SIDE EFFECTS

I understand that potential risks include, but are not limited to:

- Pain or discomfort
- Redness
- Swelling
- Bruising
- Tenderness
- Minor bleeding
- Itching or irritation
- Temporary skin sensitivity
- Infection
- Delayed healing
- Skin discoloration
- Scarring
- Injury to surrounding tissue
- Dizziness or fainting related to blood collection
- Unsatisfactory or limited cosmetic results
- Need for additional treatment

Although uncommon, complications may occur despite appropriate technique and precautions.

5. CONTRAINDICATIONS AND MEDICAL HISTORY

I agree to inform my provider if I have or have had conditions that may affect treatment, including bleeding disorders, significant anemia, active infection, certain blood disorders, immune conditions, or other conditions identified during my consultation.

I will provide an accurate list of medications and supplements, including anticoagulants, antiplatelet medications, and supplements that may affect bleeding.

I understand that I should not stop a prescribed medication without first discussing it with the prescribing provider.

6. ALTERNATIVES

I understand that alternatives may include no treatment or other cosmetic treatments. My provider may discuss alternatives appropriate for my individual goals.

7. NO GUARANTEE

I understand that cosmetic treatments cannot guarantee a specific result. Results vary based on individual factors, treatment area, skin condition, age, lifestyle, healing response, and other factors.

8. CONSENT

I have had the opportunity to ask questions regarding PRP treatment, its potential benefits, risks, alternatives, and expected results. My questions have been answered to my satisfaction.

I voluntarily consent to PRP treatment.

Patient/Legal Representative Signature: _____

Date: _____

Provider Signature: _____

Date: _____