KP Aesthetics
Consent for PRP Injections/Microneedling

I, _____ herby give KP Aesthetics and its associates to perform PRP injections for one of the following treatments: Hair rejuvenation, facial rejuvenation, facial scarring or stretch marks. I also consent to any other medical procedure that is a necessary part of the treatment which includes, but is not limited to, blood draws and application of anesthetics, both topically and injected. A fraction of blood (11-22 cc) will be drawn into an individual tube and placed into a centrifuge which will separate the plasma from red blood cells. The platelet rich plasma (PRP) is what will be used during your treatment.

I declare that I have allergies to:

_____
_____
_____

I declare that I do not have any of the following conditions which would not make me a candidate for treatment:

Current infections
Current cancer or chemotherapy treatments
Severe metabolic or systemic disorders
Abnormal platelet function (blood disorders)
Current use of corticosteroids
Recent steroid injections
Skin diseases such as lupus or porphyria
Liver disease
History of Hemoglobin below 10gr/dL
Anticoagulation disorder or therapy
Untreated anemia
Pregnancy or Breastfeeding

I understand:

_____ I should discuss any other medical conditions, concerns and with my practitioner before treatment.

_____ I may have pain or itching at the injection site.

_____ Bleeding, bruising, swelling or infection may occur.

_____ Dizziness, fainting or drop in blood glucose levels may occur.

_____ Photographs will be taken to track progress of treatment. They may be used for marketing purposes unless I specifically decline on this consent.

_____ Although these treatment are highly effective, no treatment is ever guaranteed due to the fact that individual results vary.

I also understand this procedure is “elective” and not covered by insurance and that payment is my responsibility. Any expenses which may be incurred for medical care I elect to receive outside of this office, such as, but not limited to dissatisfaction of my treatment outcome will be my sole financial responsibility. Payment in full for all treatments is required at the time of service and is non-refundable. I hereby give my voluntary consent to this PRP procedure and release KP Aesthetics’ medical staff and specific technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age and am not under the influence of alcohol or drugs. I agree, if I should I have any questions or concerns regarding my treatment/ results I will notify this office at 484-420-4094 immediately so that timely follow-up and intervention can be provided.

_____

Patient Name (print)/ Patient Signature Date

_____

Witness Name (print)/ Witness Signature Date

_____

Provider Name (print)/ Provider Signature Date