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INFORMED CONSENT — PRP / PRF / EZ GEL MICRONEEDLING & INJECTIONS

Patient Name: _____ **DOB:** _____ **Date:** _____

1. PROCEDURE

I consent to platelet-rich plasma (PRP), platelet-rich fibrin (PRF), and/or EZ Gel treatment for cosmetic and regenerative purposes, including microneedling and/or injections to the face, scalp, neck, under-eye area, or other treatment areas.

2. REGENERATIVE TREATMENT EXPLANATION

PRP and PRF are derived from my own blood and processed to concentrate platelets, fibrin, and growth factors. EZ Gel is an autologous biologic filler created from processed plasma products. I understand regenerative response varies significantly between individuals.

3. OFF-LABEL USE

I understand certain uses of PRP, PRF, and EZ Gel may be considered off-label and not FDA-approved for all cosmetic or regenerative indications.

4. RISKS AND COMPLICATIONS

Risks include but are not limited to redness, swelling, bruising, bleeding, tenderness, infection, acne flare, nerve irritation, allergic reaction to topical products, post-inflammatory hyperpigmentation, delayed inflammatory response, scarring, herpes simplex reactivation, asymmetry, lumpiness, and unsatisfactory results.

☐ I acknowledge regenerative treatment risks Initials _____

5. SCALP INJECTION RISKS

Scalp injections may cause temporary soreness, pinpoint bleeding, swelling, bruising, headache, tenderness, temporary shedding, and variable hair growth response. Results are not guaranteed.

☐ I acknowledge scalp injection risks Initials _____

6. BLOOD DRAW / AUTOLOGOUS PRODUCT RISKS

I understand treatment requires blood draw and processing of my blood products. Risks include bruising, dizziness, fainting, clotting, discomfort, and inability to obtain adequate sample quality.

7. MEDICAL DISCLOSURE & CONTRAINDICATIONS

I declare I do not have any of the following conditions which might otherwise not make me a candidate: allergy, current infections, herpes, skin diseases such as lupus or porphyria, nerve or muscle conditions, current cancer, current chemotherapy or radiation treatments, severe metabolic or systemic disorders, liver disease, abnormal platelet function (blood disorders), low platelet count, anticoagulation therapy (warfarin, coumadin, Plavix, clopidogrel, Eliquis, Brilinta, Xarelto, and others), current use of corticosteroids.

Prior filler or botox injections, and prior micro needling treatments (and dates if applicable).

Medications / Supplements:

ALLERGY DISCLOSURE:

List any allergies: _____

Pregnancy:

☐ Not pregnant / not breastfeeding — Initials _____

☐ Understand contraindication — Initials _____

8. EXPECTATIONS & MULTIPLE SESSIONS

I understand multiple sessions may be required and results vary based on age, genetics, health, hair loss pattern, skin condition, and biologic response. Results are gradual and not guaranteed.

9. COMPLIANCE & AFTERCARE

I agree to follow all pre- and post-care instructions. Failure to comply may increase risks and reduce effectiveness.

10. NO GUARANTEE

No guarantees or warranties have been made regarding outcomes.

11. FINANCIAL RESPONSIBILITY

All procedures are elective and non-refundable.

Patient Signature: _____ Date: _____

12. PHOTOGRAPHY CONSENT

☐ Medical documentation only ☐ Marketing use including partial facial features and scalp images. I understand images may be used publicly and may not be retractable once published. Initials _____

13. NO MEDICAL CLAIM

These regenerative procedures are cosmetic and not intended to diagnose, treat, or cure medical conditions.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____