Adolescent & Women Medical Care

VAMPIRE HAIR REGROWTH

CONSENT FOR PROCEDURE

I have receive information about my condition, the proposed treatment, alternatives and related risks. I have received an explanation of any unfamiliar terms and have been offered the opportunity to ask questions. I understand I may refuse consent and I GIVE MY INFORMED AND VOLUNTARY CONSENT to the proposed procedure. I authorize Dr. Angelica Hernandez to treat my condition, including performing further diagnosis and the procedures described below, and taking any needed photographs.

I understand the proposed procedure to be inject the Platelet Rich Plasma (PRP) into the areas of the scalp using tiny needles.

I understand that there may be other risks or complications, or serious injury from both known and unknown causes. I am aware that the practice of medicine is not an exact science.

I acknowledge that no guarantees have been made to me concerning the effectiveness of the procedure. I understand the alternatives to the proposed procedures.

CONSENT FOR ANESTHESIA

When local anesthesia is used by the physician:

I consent to the administration of such local anesthetics as may be considered necessary by the physician in charge of my care. I understand that the risks of local anesthesia include local discomfort, swelling, bruising, and allergic reactions to medications, and seizures from the excess of lidocaine.

There is a potential for bruising at the injection sites. Pain from bruising could occur. Smokers have less positive response to this treatment than non-smokers, since the toxins in cigarette smoke block the response of the stem cells. There may be some variation in achieving the results requested as everyone's body type is different and may have a different response.

I have read and understand all information presented to me and authorized Dr. Angelica Hernandez of Adolescent & Women Medical Care to administer the vampire hair regrowth procedure on me. I have had ample opportunity to ask questions concerning the treatment. I understand that this treatment involves the Doctor injecting the scalp with PRP. I am aware of the health risks and/or side effects that could results from such treatment. I fully consent to treatment and agree to hold Adolescent & Women Medical Care, Dr. Angelica Hernandez and any and all parties affiliated therewith, harmless and free from any liability that may arise as a result of this treatment both now and in the future.

Patient name: _____

Signature: _____

Date: _____