Conifer
MEDICAL AESTHETICS

PRF CONSENT

PATIENT ____________________

DATE OF BIRTH ____________________

DATE____________________

INSTRUCTIONS: This is an informed consent document that has been prepared to help inform you about the Platelet Rich Fibrin (PRF) technique. It is important that you read this information carefully and completely. Please initial each section, indicating that you have read the page and sign the consent for the procedure proposed by your practitioner.

POSSIBLE RISKS AND SIDE EFFECTS ASSOCIATED WITH PRF

1. DISCOMFORT: Discomfort may be experienced during blood draw where there is a slight pinch to insert the needle for the blood collection as well as during the procedure if PRF is injected into the site. Repeat injections may be necessary.
2. BRUISING, SWELLING, INFECTION: With any minimally invasive procedure, bruising of the treated area may occur. Additionally, there may be swelling noted. Finally, skin infection is rare, but always a possibility with any injection or incision into the skin.*
3. SCARRING: Scar at entry point is extremely rare but must always be considered a possibility when entering the skin. Delayed wound healing and/or scarring may occur. *
4. CONTRAINDICATIONS: Smokers may have less response to this treatment as toxins in smoke block the response of the Stem Cells. Cell death or Fibrosis may occur.
5. There may be some variation I achieving the results requested as everyone's body type is different and may have a different response. No guarantees or warrantees with respect to final outcome or its longevity can be offered.

26659 Pleasant Park Road, Conifer, CO 80433
303-647-5307

Conifer
MEDICAL AESTHETICS

CONSENT:

Your consent and authorization for this procedure is strictly voluntary. By signing this informed consent form, you hereby grant authority to your physician/practitioner to use PRF for regeneration purposes and/or to administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of your condition.

The nature & purpose of this procedure and the potential complications & side effects have been fully explained to me I agree to adhere to all safety precautions and instructions after the treatment. I have been instructed in and understand post treatment instructions and have been given a written copy of them. I understand that No refunds will be given for treatments received. No guarantee has been given by anyone as to the results that may be obtained by this treatment. I acknowledge that I have been informed about the Off-Label FDA status of dermal fillers and I understand it is not experimental and accepts its use.

I have read this informed consent and certify that I understand its contents in full. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I have had enough time to consider the information given me by my physician/practitioner and feel that I am sufficiently advised to consent to this procedure. I accept the risks and complications of the procedure. I certify if any changes occur in my medical history I will notify the office.
I hereby give my voluntary consent to this procedure and release my practitioner, the facility, 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. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Should I have any questions or concerns regarding my treatment / results, I will notify Conifer Medical Aesthetics at 303-647-5307 immediately so that timely follow-up and intervention can be provided.

____

Patient Name (Print) Patient Signature Date

____

Practitioner Name (Print) Practitioner Signature Date

26659 Pleasant Park Road, Conifer, CO 80433
303-647-5307