



THERAPY WITH PRF INFORMED CONSENT

I, _____, understand that I will be treated with platelet rich fibrin (PRF) to rejuvenate the skin and/or assist in wound healing of other treatments.

It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for the procedure as proposed.

THE TREATMENT

Platelet Rich Fibrin (PRF) is a therapy whereby a person's own blood is used. A fraction of blood (20cc-60cc) is drawn up from the individual patient into vials. This is a relatively small amount compared to blood donation which remove ~300cc or more. The blood is spun down in a special centrifuge (BIO-PRF®) to separate its components (Red Blood Cells, and Plasma). The platelet rich fibrin layer is then collected rich in cells and growth factors to allow the release of growth factors from the platelets which in turn amplifies the healing process. PRF can then be micro-needled or injected into the area of the skin. Platelets are very small cells in your blood that are involved in the clotting process. When PRF is injected into the damaged area it causes a mild inflammation that triggers the healing cascade. As the platelets organize in the clot, they release a number of growth factors to promote healing and tissue responses including attracting stem cells to repair the damaged area. As a result, new collagen begins to develop. As the collagen matures it begins to shrink causing the tightening and strengthening of the damaged area. When treating injured or sun and time damaged tissue they can induce a remodeling of the tissue to a healthier and younger state. The full procedure takes approximately 30 minutes to 1 hour. Generally, 2-3 treatments are advised, however, more may be indicated for some individuals. Touch up treatment may be done once a year after the initial group of treatments to boost and maintain the results.

As a whole, PRF therapy is the safest facial esthetic procedure available since the growth factors are coming directly from you, thereby no chemicals or additives are utilized. The procedure is well-tolerated and, in some cases, virtually painless, feeling only a mild prickling sensation. A topical anesthetic cream will be applied to your skin prior to treatment to reduce any pain or discomfort. Following therapy, your skin will be pink or red in appearance, much like a sunburn, for a couple of hours following treatment. Minor bleeding and bruising are possible depending on the needles used for injection purposes but generally heal entirely within 12-48 hours. Following treatment, your skin will generally feel tighter and warmer as a result of increased stimulation and blood flow to the area.

Along with the benefit of using your own tissue therefore eliminating allergies there is the added intrigue of mobilizing your own stem cells for your benefit. PRF has been shown to have overall rejuvenating effects on the skin as in: improving skin texture, fine lines and wrinkles, increasing volume via the increased production of collagen and elastin, and by diminishing and improving the appearance of

scars. Other benefits: minimal down time, safe with minimal risk, short recovery time, natural looking results, no anesthesia required.

RISKS

Though PRF is considered one of if not the safest therapies in facial esthetics, every procedure involves a certain amount of risk and it is important that you understand these risks and the possible complications associated with them. In addition, every procedure has limitations. An individual's choice to undergo an elective procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience any complications, you should discuss each of them with your doctors to make sure you understand risks, potential complications, limitations, and consequences of PRF therapy.

Initial ____

The following information is specific to PRF:

1. Although a very small needle is used, common injection related reaction could occur. Likely effects include some initial swelling, pain, itching, potential bruising or tenderness at the injection site. You could experience increased bruising or bleeding at the injection site if you are using substance that reduce blood clotting such as aspirin or non-steroidal anti-inflammatory drugs such as Advil or Ibuprofen.
2. These reactions generally lessen or disappear within a day or two.
3. Minor flaking or dryness of the skin with scab formation may occur in rare cases.
4. As with injections, this procedure carries a risk of infection. The syringe is sterile and standard precautions associated with injectable materials have been taken but infection of the injection site is a possibility (though extremely rare).
5. Needle Marks: Visible needle marks from the injections occur normally and resolve in a day or two.
6. Some visible lumps may occur temporarily following the injection. After the swelling has gone down, you may be able to feel bumps but they should no longer be visible.
7. Most patients are pleased with the results of PRF. However, like any cosmetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles or folds will disappear completely, or that you will not require additional treatments to achieve the results you seek. While the effects of PRF can last longer than expected in many individuals, the procedure is still temporary. Additional treatments will be required periodically, generally within 6 months to a year.
8. After treatment, you should minimize exposure of the treated area to excessive sun or UV lamp exposure and extreme cold weather until any initial swelling or redness has gone away.
9. ***I will follow all aftercare instructions as it is crucial I do so for healing.***

Mental Health Disorders and Elective Surgery: It is important that all patients seeking to undergo elective surgery have realistic expectations that focus on improvement rather than perfection. Complications or less than satisfactory results are sometimes unavoidable, may require additional treatment and often are stressful. Please openly discuss with your doctor, any history that you may have of significant emotional depression or mental health disorders. Although many individuals may benefit psychologically from the results of elective surgery, effects on mental health cannot be accurately predicted.

Sun Exposure – Direct or Tanning Salon: The effects of the sun are damaging to the skin. Exposing the treated areas to sun may result in increased scarring, color changes, and poor healing. Patients who tan, either outdoors or in a salon, should inform their doctor and avoid tanning for 1 week before and after treatment. The damaging effect of sun exposure occurs even with the use sun block or clothing coverage.

Additionally,

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent PRF treatments with the above understood. I hereby release the doctor, the person injecting the PRF and the facility from liability associated with this procedure.

Initial _____

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenic gravis, multiple sclerosis, amyotrophic lateral sclerosis (ALS), and Parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin.

Initial _____

ALTERNATIVE PROCEDURES

This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments include but are not limited to Botox, Laser skin modalities, fillers and other cosmetic surgery.

Initial _____

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

Initial _____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

Initial _____

PHOTOGRAPHY

If Pre and Post-Treatment photos and/or videos are taken of the treatment for record purposes; I understand that these photos will be property of CARE ESTHETICS®. I understand that these photos may be used for diagnostic, educational, advertising, scientific/teaching purposes, or record keeping purposes. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

Initial _____

RESULTS

PRF been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effect can last up to 6 months. Most patients are pleased with the results of PRF therapy and microneedling. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. PRF therapy is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to 6 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions.

Initial _____

I understand this is an elective procedure and I hereby voluntarily consent to treatment with PRF for facial rejuvenation, lip enhancement, and replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical

history, I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

Initial _____

CONSENT

Your consent and authorization for this procedure is strictly voluntary. By signing this consent form, you hereby grant authority to the doctor to perform facial rejuvenation/augmentation with PRF for any related treatment as may be deemed medically necessary or advisable in the treatment areas you so choose. The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications, have been fully explained to my satisfaction.

No guarantee has been given as to the results that may be obtained by this treatment. I have read this informed consent form and certify that I understand its contents in full. I have had enough time to consider this information and I feel that I can sufficiently advise to consent to this procedure. I hereby give my consent to this procedure and have been asked to sign this form after being fully informed of the risks and benefits involved.

Initial _____

The details of this procedure have been explained to me in terms of:

- Alternative methods and their benefits and disadvantages have been explained to me.
- I am aware that smoking during the pre and post-operative periods could increase chances of complications.
- I have informed the doctor or nurse of all my known allergies, including allergies to latex.
- I have informed the doctor or nurse of all medications I am currently taking including prescriptions, over the counter medications/remedies, herbal therapies and any other.
- I am aware and accept that no guarantees regarding the result of this procedure have been made or implied.
- Prices are subject to change. The pricing I receive during this treatment is only for today's treatment. Any additional treatments, products or services will be billed at rates effective at time of the additional treatments.
- I am not currently pregnant or nursing.
- I have been advised to seek immediate medical attention if swallowing, speech, or respiratory disorders arise.
- I certify that I have read and understand this agreement and that all spaces for initials were filled prior to my signature

Patient Name (Print)

Patient Signature

Date



LASER THERAPY INFORMED CONSENT

I, _____, understand that I will be treated with a combination of Nd:Yag and/or Erb:Yag laser therapy using light-based therapy methods.

It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for the procedure as proposed.

THE TREATMENT

Lasers have been used in medicine for many years with the Fotona laser system having 50+ years of experience. There are many different ways to improve facial appearance with lasers. Laser energy can be used to cut, vaporize, or selectively remove skin and deeper tissues. Conditions such as wrinkles, sun damaged skin, hair removal, vascular lesions/vein removal, mole removal, acne scars, and some types of skin lesions/disorders may be treated with lasers. Certain surgical procedures may use the laser as a cutting instrument. In many cases, laser treatments can be combined with other procedures such as micro-needling with PRF. Skin treatment programs may be used both before and after laser skin treatments in order to enhance the results. Lasers are cleared and FDA approved for such uses owing to their overall positive results and experiences amongst patients.

Although laser treatment is effective in the majority of cases, no guarantee can be made that every patient will experience the same benefit from the treatment. The purpose of this selected light-based therapy treatment is an attempt to improve the appearance of facial tissues. Normally, multiple consecutive treatments are necessary to achieve desired outcomes. Treatment is repeated, within protocol, until the desired level of appearance is observed. The laser emits an intense beam of light that is absorbed in specific body tissues within the skin, and depending upon the type of procedure, several treatments may be required at intervals specified by the doctor.

RISKS

Every procedure involves a certain amount of risk and it is important that you understand these risks and the possible complications associated with them. In addition, every procedure has limitations. An individual's choice to undergo an elective procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience these complications, you should discuss each of them with your doctors to make sure you understand risks, potential complications, limitations, and consequences of LASER THERAPY injections.

There are both risks and complications associated with all laser treatment procedures of the skin. Risks involve both items that specifically relate to the use of laser energy as a form of surgical therapy and to the specific procedure performed.

An individual's choice to undergo a procedure is based on the comparison of risk to potential benefits. Although the majority of patients do not experience these complications, you should discuss each of them with your doctor to make sure you understand the risks, potential complications and consequences of laser skin treatment.

1. Discomfort – The procedure is done so precisely that surrounding tissue are not/minimally affected. The patient will typically feel a sensation of tightness of the face following therapy (a bit like a sunburn). Patient may experience a mild sensation of burning, blister formation, crusting of the skin and stinging sensation, in the treated areas. Irritation and redness typically resolve within 24-72 hours or less. A topical anesthetic (Emla or LMX) will be used to minimize discomfort.
2. Infection - Although infection following laser skin treatment is unusual and rare, bacterial, fungal, and/or viral infections can occur. Herpes simplex virus infections around the mouth or other areas of the face can occur following a laser treatment. This applies to both individuals with a past history of Herpes simplex virus infections and individuals with no known history of Herpes simplex virus infections in the mouth area. The patient agrees to notify the physician if he/she has any history of Herpes viral infections (oral, nasal, genital) as the laser procedure may cause it to reactivate. Laser-induced cold sore-like blistering may appear. It is recommended that Valtrex (acyclovir) be taken prior to treatment to avoid an outbreak and suppress an infection from this virus. Should this occur, notify your doctor.
3. Blistering or Scarring - Although normal healing after the procedure is expected, abnormal scars may occur both in the skin and deeper tissues. In rare cases, keloid scars may result. Scars may be unattractive and of different color than the surrounding skin. Additional treatments may be needed to treat scarring.
4. Burns - Laser energy can produce burns. Adjacent structures can be injured or damaged by the laser beam. Burns are rare yet represent the effect of heat produced within the tissues by laser energy. Additional treatment may be necessary to treat laser burns.
5. Color Change - Laser treatments may potentially change the natural color of your skin. Skin redness usually lasts 2 days. There is the possibility of irregular color variations within the skin including areas that are both lighter and darker. Color changes, such as Erythema (pink color), hyperpigmentation (darker, brown, red), hypopigmentation (skin lightening) may occur in treated areas. These are temporary and will fade within 1-6 months. Avoid sun exposure before and after treatment as exposure to the sun may intensify the pigment changes. It is rare that a change is permanent.
6. Accutane (Isotretinoin) - Accutane is a prescription medication used to treat certain skin diseases such as acne. This drug may impair the ability of skin to heal following treatments or surgery for a variable amount of time even after the patient has ceased taking it. Individuals who have taken the drug are advised to allow their skin adequate time to recover from Accutane before undergoing laser skin treatment procedures.
7. Skin Tissue Pathology - Laser energy directed at skin lesions may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible.

8. Patient Failure to Follow Through - Patient follow through after a laser skin treatment procedure is important. Postoperative instructions concerning appropriate restriction of activity, and use of skincare/sun protection need to be followed in order to avoid potential complications, increased pain, and unsatisfactory result.
9. Your doctor will recommend that you utilize a long-term skin care program to enhance healing following a laser skin treatment.
10. Damaged Skin - Skin that has been previously treated with chemical peels or dermabrasion, or damaged by burns, electrolysis (hair removal treatments), or radiation therapy may heal abnormally or slowly following treatment by lasers or other surgical techniques. The occurrence of this is not predictable.
11. Lack of Treatment Response – There is a possibility that the targeted hairs, veins or other treated areas will not respond to the treatment. This is often a function of the specific body chemistry of the patient, including relative pigmentation and light absorption characteristics of the patient's various body tissues. Reoccurrence of hair growth at treatment site is also a possibility.
12. Pain - Very infrequently chronic pain may occur after laser skin treatment procedures.
13. Lack of Permanent Results - Laser therapy or other natural treatments may not completely improve skin wrinkles, lesions, etc long-term. Additional procedures may be necessary to further tighten loose skin.
14. Unknown Risks - There is the possibility that additional risk factors of laser skin treatments may be discovered.
15. Although good results are expected, there is no guarantee or warranty expressed or implied on the results that may be obtained.

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Sun Exposure – Direct or Tanning Salon: The effects of the sun are damaging to the skin. Exposing the treated areas to sun may result in increased scarring, color changes, and poor healing. Patients who tan, either outdoors or in a salon, should inform their doctor and avoid tanning for 1 week before and after treatment. The damaging effect of sun exposure occurs even with the use sun block or clothing coverage.

Additionally,

While the doctor will recommend a certain volume to be injected, the actual volume injected is an estimate of the amount required. I understand there is no guarantee of results of any treatment. I understand the regular charge applies to all subsequent treatments and that additional volume may be needed.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent LASER THERAPY treatments with the above understood. I hereby release the doctor, and the facility from liability associated with this procedure.

Initial _____

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenic gravis, multiple sclerosis, amyotrophic lateral sclerosis (ALS), and Parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin.

Initial _____

ALTERNATIVE PROCEDURES

This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments include but are not limited to Botox, dermal fillers, platelet-rich concentrates and other cosmetic surgery.

Initial _____

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

Initial _____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

Initial _____

PHOTOGRAPHY

If Pre and Post-Treatment photos and/or videos are taken of the treatment for record purposes; I understand that these photos will be property of CARE ESTHETICS®. I understand that these photos may be used for diagnostic, educational, advertising, scientific/teaching purposes, or record keeping purposes. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

Initial _____

MANDATORY EYEWEAR

With lasers, there is also the risk of harmful eye exposure. Safeguards should be provided and worn by the laser practitioner. It is important that you keep your eyes closed and have protective eye wear at all times during the laser treatment.

Initial _____

RESULTS

LASER THERAPY has been shown to be a safe and effective when compared to collagen skin implants, dermal fillers, Botox and other related products to fill in wrinkles, lines and folds in the skin on the face. Its effect can last typically 6 months or longer. Most patients are pleased with the results of LASER THERAPY. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The laser therapy procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to 6 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions.

Initial _____

I understand this is an elective procedure and I hereby voluntarily consent to treatment with LASER THERAPY for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and enhancing facial tightness. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

Initial _____

CONSENT

Your consent and authorization for this procedure is strictly voluntary. By signing this consent form, you hereby grant authority to the doctor to have laser therapy. The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications, have been fully explained to my satisfaction.

No guarantee has been given as to the results that may be obtained by this treatment. I have read this informed consent form and certify that I understand its contents in full. I have had enough time to consider this information and I feel that I can sufficiently advise to consent to this procedure. I hereby give my consent to this procedure and have been asked to sign this form after being fully informed of the risks and benefits involved.

Initial _____

The details of this procedure have been explained to me in terms of:

- Alternative methods and their benefits and disadvantages have been explained to me.
- I am aware that smoking during the pre and post-operative periods could increase chances of complications.
- I have informed the doctor or nurse of all my known allergies, including allergies to latex.
- I have informed the doctor or nurse of all medications I am currently taking including prescriptions, over the counter medications/remedies, herbal therapies and any other.
- I am aware and accept that no guarantees regarding the result of this procedure have been made or implied.
- Prices are subject to change. The pricing I receive during this treatment is only for today's treatment. Any additional treatments, products or services will be billed at rates effective at time of the additional treatments.
- I am not currently pregnant or nursing.
- I have been advised to seek immediate medical attention if swallowing, speech, or respiratory disorders arise.
- I certify that I have read and understand this agreement and that all spaces for initials were filled prior to my signature

Patient Name (Print)

Patient Signature

Date