



METROPOLITAN  
ANTI-AGING • BEAUTY • WELLNESS

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

## PRP (PLATELET RICH PLASMA) CONSENT FORM

PRP (Platelet Rich Plasma) is a natural product derived from your own body used to help tissue heal and grow new cells. PRP is processed from a small sample of your blood to produce a plasma that is rich in platelets. The plasma is applied topically, injected or a combination of both to help the tissue heal and regenerate new cells for increased elasticity and improved skin tone while lines and wrinkles soften and recede. The regenerative process resulting from PRP is used as an excellent combination treatment for acne and scar revision.

**Please initial the following:**

- \_\_\_\_\_ I hereby request and authorize the use of PRP for cosmetic purposes and understand this procedure requires a simple blood draw.
- \_\_\_\_\_ The details of the procedure have been explained to me in terms I understand and I have no further questions.
- \_\_\_\_\_ Alternative methods and their benefits and disadvantages have been explained to me.
- \_\_\_\_\_ I understand PRP involves a series of treatments to achieve optimum results and the fee structure has been fully explained to me. The fee is for the series of treatments purchased and includes post treatment follow-up visits. There will be a charge for additional treatments.
- \_\_\_\_\_ Services purchased are non refundable unless the Metropolitan is unable to perform the treatment(s).
- \_\_\_\_\_ I understand the effects of this treatment are gradual, as the healing process of platelets and growth factors stimulate a stem cell response that naturally helps collagen regenerate over time.
- \_\_\_\_\_ I understand and accept the most likely risks and complications of PRP.
- \_\_\_\_\_ I understand with any facial injections it is unlikely, but possible, small blood vessels could be broken which could result in temporary swelling, bruising, redness, and soreness.
- \_\_\_\_\_ I have informed my technician if I have previously been injected with resorbable or permanent cosmetic fillers.
- \_\_\_\_\_ I understand any injection carries a minimal but potential risk of infection.
- \_\_\_\_\_ I have informed my injectionist of all my known allergies.
- \_\_\_\_\_ I have no muscle or nerve conditions.
- \_\_\_\_\_ I have not had chemotherapy or radiation treatments within the last 12 months.
- \_\_\_\_\_ I have not used Accutane (isotretinoin) in the past 12 months.
- \_\_\_\_\_ I am not currently pregnant or breastfeeding.
- \_\_\_\_\_ I have informed my injectionist of all medications I am currently taking including prescriptions, over the counter remedies, herbal therapies, and any other(s).
- \_\_\_\_\_ I have been advised whether I should take any or all of the medications on the days surrounding the procedure.
- \_\_\_\_\_ I am aware and accept that no guarantees about the results of the procedure have been made or implied.
- \_\_\_\_\_ I have been informed of what to expect post-treatment, including, but not limited to procedures, if I wish to maintain the appearance this procedure provides me.
- \_\_\_\_\_ I understand and agree that photographs will be taken before and after each procedure(s).

I have been candid in revealing any existing or new conditions(s) that I have. My technician has asked at this time whether I have any questions and I do not. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I understand the procedure, risks, benefits and alternatives.

**Guest Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Technician Name** \_\_\_\_\_ **Technician Initials** \_\_\_\_\_ **Date** \_\_\_\_\_