P SHOT CONSENT FORM

Tele:

INFORMATION SHEET AND INFORMED CONSENT FOR PRIAPUS SHOT®! P SHOT and/or INJECTION OF PLATELET RICH PLASMA AND ADMINISTRATION OF ANESTHESIA

It is important that you read this information carefully and completely.

The Priapus Shot® / P-Shot involves isolation of PRP (platelet rich plasma) followed by a very specific method of amplifying or augmenting the penis with injection of that **PRP. PRP** is derived from the patient's own blood in the following manner. A fraction of blood (60cc) is drawn from the individual patient into a syringe. This is a relatively small amount compared to blood donation. The blood is spun in a special centrifuge to separate its components (Red Blood Cells, Platelet Rich Plasma, Platelet Poor Plasma and White Blood Cells).

The Platelet Rich Plasma containing monocytes and various plasma proteins are collected into a syringe. A sterile Calcium Chloride 10% and sterile Bicarbonate 8.4% solution is added in 5% volume to the syringe containing PRP. Calcium Chloride and Bicarbonate both work to activate the platelets, thus leading to liberation of growth factors and healing elements. The activated platelets are then injected with in the next few minutes as a medical intervention. As the platelets organize in the clot they release a number of enzymes to promote healing and tissue responses including attracting stem cells and growth factors to repair damaged tissue and cause regeneration and rejuvenation.

The use of **PRP** in this procedure is an 'off label' use, and no promise or representation, guarantee or warranty regarding its use, benefit or other quality is made. No representation that the use of this product and this procedure is approved by the FDA or any other agency of the federal or state government is made.

RISKS OF TREATMENT

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 this procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience the following, you should discuss each of them with your physician to make sure you understand the risks, potential complications, limitations, and consequences.

Problems associated with the use of the P Shot can relate to normal occurrences following **PRP** injections or potential complications following PRP injections. I understand the risks associated with the proposed procedure(s) to be:

Temporary pain and bruising
A sensation of always being aroused
Hypersexuality (over active sex drive)
Allergic reactions
Urinary incontinence
Hematuria (blood in urine)
Injection/infection at the injection site
Decreased sensitivity
Decline sexual function

Unsatisfactory Result: PRP alone may not produce an outcome that meets your expectations. There is the possibility of a poor or inadequate response from filler injection(s). Additional injections may be necessary. Surgical procedures or other treatments may be recommended in additional to additional treatments.

Unknown Risks: The long term effect of PRP injections is unknown. The possibility of additional risk factors or complications may be discovered.

CONSENT FOR ANESTHESIA:

I understand that local anesthesia and/or sedation may be 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, allergic reactions to medications, and seizures from lidocaine.

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- I _____ have read the 2 page information sheet and hereby authorize my medical provider and/or such assistants as may be selected by my medical provider to perform the PRIAPUS SHOT®/ P SHOT and/or INJECTION OF PLATELET RICH PLASMA AND ADMINISTRATION OF ANESTHESIA.

- I understand what my medical provider can and cannot do, and understand there are no warranties or guarantees, implied or specific about my outcome. I have had the opportunity to explain my goals and understand which desired outcomes are realistic and which are not. All of my questions have been answered.

- I understand the specific risks to the procedures I seek, as well as those additional risks and complications, benefits, and alternatives. Understanding all of this, I elect to proceed.

- I understand that multiple treatments may be necessary to achieve desired results.

- I understand that clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment.

- 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. No refunds will be given for treatments received. I understand that if complications arise, I will be responsible for the cost of any treatment.

- I consent to be photographed or televised before, during, and after the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.

- For purposes of advancing medical education, or staff training, I consent to the admittance of observers to the treatment room.

- I have informed the clinical staff of any known allergies to drugs or other substances that may be included in the ingredients of my solutions, or of any past reactions to anesthetics. I have noted all of these on the patient history form.

- I have informed the clinical staff of all current medications and supplements and documented on the patient history form.

- I have informed the clinical staff of my prior medical history and documented in the patient history form.

- I understand that I may suspend or terminate my treatment at any time by informing my medical provider.

- I understand that I am experiencing any adverse effects or symptoms after I receive treatment, I will seek medical evaluation.

- I fully understand and confirm that the nature and purpose of the aforementioned treatment to be provided may be considered unproven by scientific testing and peer-reviewed publications and therefore may be considered medically unnecessary or not currently indicated.

- I understand that I can withdraw my consent at any time.

_____ Date: _____

Patient Signature

_____ Date: _____

Witness Signature