STEM CELL THERAPY INFORMED CONSENT FORM

DISCLOSURE STATEMENT

Informed consent documents are used to communicate information about the proposed treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks

Your physician may provide you with additional or different information that is based on all the facts in your particular case and the state of medical knowledge.

Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. It is important that you read the above information carefully and have all of your questions answered before signing the consent. Adult Stem Cell Therapy is within the scope of Practice of Medicine but not necessarily the "standard of care", the following important disclosures are made:

- The treatment described on our list have not been evaluated nor have yet been approved by the FDA
- Bone Marrow Concentrate is not necessarily the "standard of care", it is under the scope of the Practice of Medicine.
- The science of Adult Stem Cells is in its early stage and for most diseases or medical conditions no prospective, randomized clinical trials nor long-term studies have yet been completed; therefore no guarantee of safety or effectiveness is made or implied.
- Treatments by licensed medical doctors and/or medical practitioners will be performed after the patient understands and agrees to this disclosure and signs a standard informed consent.
- The results of testimonials of people mentioned on our website who have undergone Stem Cell treatment may not be necessarily typical

CONSENT FOR TREATMENT

1. I hereby authorize …… and such licensed assistants as may be selected to perform the following procedure or treatment: ……..
2. I have been advised and consulted about the extraction and injection technique of the treatment.
3. I have been informed that even though this is not an FDA approved procedure, this procedure has been used safely and successfully on other patients.
4. I have been advised that the procedure may not completely eradicate my symptoms.
5. I recognize that during the course of the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.
6. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury, and sometimes death.
7. I consent to the disposal of any tissue, medical devices or body parts which may be removed and not needed after the isolation of stem cells.
8. For purposes of advancing medical education, I consent to the admittance of observers to the operating room. (I will be made aware of this prior to procedure)
9. I have been informed that not having the procedure is an option.

By initialing below I confirm to have read and fully understand what is contained on this informed consent form.

10. I have been informed of the risks and complications of stem cell injections.
11. I understand that this procedure is not covered by insurance and I am responsible for the total charges of all services rendered.
12. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
13. I certify that I understand all the information above in its entirety, have received answers for all of my questions, and that I understand the potential side effects.
14. It has been explained to me in a way that I understand:
    a. The above treatment or procedure to be undertaken
    b. There may be alternative procedures or methods of treatment
    c. There are risks to the procedure, treatment, or injection proposed

I consent to the treatment or procedure and the above listed items (1-14) and I am satisfied with the explanations.

Financial responsibilities:

The cost of procedure may involve several charges for the services provided. The total may include fees charged by your doctor/practitioner, the cost of supplies, or laboratory tests if needed. Additional costs may occur should complications develop from the procedure.

PREGNANCY AND ALLERGIES

I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving the treatment. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine.

I am the licensed physician. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

_____

Provider Name Provider Signature Date