INFORMED CONSENT

Bone Marrow Aspiration Concentration (BMAC) Stem Cells
-and-
Platelet Rich Plasma (PRP)

I, _____ have been advised and consulted about the injection
(patient name)
techniques of BMAC stem cells and of PRP for the treatment of neurological and orthopedic conditions.

_____ I understand and voluntarily consent to the following procedures:

1) Harvest bone marrow aspiration from my iliac crest (hip bone) under local anesthesia
2) Concentrate the bone marrow aspiration using centrifuge
3) Re-inject my own BMAC derived stem cells back into the affected area, degenerative joint or damaged tissue.

_____ I understand the procedure may (or may not) require follow-up injection treatment.

_____ I have been informed that even though this procedure is not yet FDA approved, it has been used safely and successfully on many other patients.

_____ I have been advised that the procedure may initially increase the painful area or reproduce symptoms for one to three days (and occasionally, as long as ten days), and then may decrease in intensity, but may not completely eradicate my symptoms.

_____ GOALS: I understand the possible benefits of the procedure are to improve or resolve pain and/ improve function.

_____ I acknowledge that NO GUARANTEE has been given by the doctor nor anyone else as to the results that I may have.

_____ I have been informed that the alternatives to bone marrow aspirate concentrate and or PRP injections are:

- Conventional Surgical Intervention
- Injection with steroids
- Acupuncture or more physical therapy
- chronic pain medications
- continued observation

_____ I have been informed that the risks and complications of stem cell injections are:

- Immediate pain at the injection sight
- Bruising or minor bleeding
- Infections
- Nausea/vomiting
- Nerve or muscle injury
- Stiffness in the injected point
- Allergic reaction
- Dizziness or fainting
- Itching at the injection site
- failure to alleviate symptoms
- post spinal tap headaches

_____ I have been informed that the risks of not having the treatment are:

- No pain relief
- No improvement in weakness or numbness
- probable worsening of pain and other symptoms over time

_____ I understand that this procedure is usually NOT covered by insurance and I am responsible for the total agreed upon charges.

_____ I certify that I understand all the information above in its entirety, have had my questions answered, and the potential side effects explained to my satisfaction.

_____

Patient's Signature Date

_____

Surgeon's Signature Date

_____

Witness Signature Date