**INFORMED CONSENT**

**Adipose-Derived Adult Stem Cell Harvesting and Transfer**

I,________________________________________ hereby authorize ______________________________

and such assistants as many be selected to perform the following procedure or therapy:

____________________________________________________________________________________

_____ I consent to the administration of such anesthetics consider advisable and I understand that all forms of anesthesia involve risk and the possibility of complications, injury, and sometimes death.

_____ I have been advised and consulted about transfer technique of adipose derived stem cells and of platelet rich plasma, I understand and voluntarily consent and authorize the following procedure: re-injection of my own adipose-derived stem.

_____ I have been advised that ASCs therapy can potentially increase vascularity and consequently improve function .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.

_____ I have been advised that the technique requires the re-injection of stem cells derived from my own adipose tissue according to standard fat harvesting and injection techniques. The site of injection is within a specific area to treat or by IV infusion. I have been advised that the procedure may initially cause or increase pain when injected in an specific area and then may decrease in intensity, but may not completely eradicate my symptoms.

_____ I have been advised that PRP and growth factors could "direct" and "activate" the stem cells. The technique requires the injection of Platelet Rich Plasma derived from my own blood according to standard blood collection and injection techniques.

_____ I consent to the disposal of any tissue removed and not needed after the isolation of the stem cells.

_____ I have been informed that not having the procedure is an option.

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

*Bruising *Allergic reaction *Dizziness or fainting *Infection

*Swelling *Nause/Vomiting *Itching at injection site *Nerve or Muscle injury

*Bleeding *Stiffness in the injection point *immediate pain *Temporary blood sugar increase

_____ I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

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

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

________________________________ ________________________________

Participant's Signature/Date Consultant's Signature/ Date