Consent for O-Shot

Orgasm Shot Procedure: Vaginal Submucosal/Suburethral, Clitoral, and /or Labial Injection of Platelet Rich Plasma and Administration of Anesthesia

A. CONSENT FOR "O" SHOT PROCEDURE

I have received information about my condition, the proposed treatment, alternatives, and related risks. This form contains a brief summary of this information. I have received an explanation of any unfamiliar terms and have been offered the opportunity to ask questions. I have not received any promise, guarantee or warranty that my undergoing the "O" Shot procedure will achieve a particular result. I fully understand that individual results do vary, and that Dr. Veronica Solis-Rohr assumes no responsibility for failure to achieve a desired result. I understand I may refuse consent and I GIVE MY INFORMED AND VOLUNTARY CONSENT to the proposed procedures and the other matters shown below. I also consent to the performance of any additional procedures determined in the course of a procedure to be in my best interests if a delay might impair my health.

1. I authorize Dr. Veronica Solis-Rohr to treat my condition, including performing further diagnosis, and the procedures described below, and taking any needed photographs.

2. I understand the proposed "O" Shot procedure to be: a procedure for vaginal, labial, and clitoral rejuvenation, using blood-derived growth factors - platelet-rich fibrin matrix (PRFM) and platelet-rich plasma (PRP) injections.

3. I understand the rare but possible risks associated with the proposed procedure(s) to be: Bleeding; infection; urinary retention; no effect at all; allergic reactions; constant awareness of the G-Spot; sensation of always being sexually aroused; constant vaginal wetness, mental preoccupation of the GSpot; altered sexual function; hematuria (blood in the urine), UTI (Urinary Tract Infection), urinary urgency (feel like you always have to urinate); urinary frequency; increased/worsening nocturia (waking up several times at night to urinate); change in urinary stream, urethral vaginal fistula (hole between urethra and vagina); vesico-vaginal fistula (hole between urethra and vagina); dyspareunia (painful intercourse); need for subsequent surgery; Alteration of vaginal sensation; Scar formation (vaginal); urethral stricture (abnormal narrowing of the urethra); local tissue infarction and necrosis; yeast infection; vaginal Discharge; spotting between periods; bladder pain; overactive bladder; bladder fullness; exposed Material; pelvic pain; pelvic heaviness; erosions; fatigue; damage to nearby organs including bladder, urethra and ureters; alteration of bladder dynamics; post-operative pain; prolonged pain; intractable pain; alteration of the female sexual response cycle; failed procedure; varied results; psychological alterations; relationship problems; sex life alterations; decreased sexual function; possible hospitalization for treatment of complications; anesthesia reaction; embolism; depression; reaction to medications including anaphylaxis; nerve damage; permanent numbness; slow healing; swelling; sexual dysfunction;

allergy; nodule formation.

4. I also understand that there may be other RISKS OR COMPLICATIONS, OR SERIOUS INJURY from both known and unknown causes. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the risks of the procedure.

5. I understand that 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 representations 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. I understand the alternatives to the proposed procedures: to do nothing, and the related risks as outlined above.

CONSENT FOR ANESTHESIA

When local anesthesia and/or sedation is 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 medicines and seizures from lidocaine.

B. PATIENT CERTIFICATION:

By signing below, I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form. I understand the information on this form and give my consent to what is described above and to what has been explained to me.

Client Signature:_____

Client Name:_____

Date Reviewed and Signed:_____