CAPSTONE
MEDICAL ASSOCIATES

Consent for
Vaginal Submucosal/Suburethral, Clitoral, and/or Labial Injection of Platelet Rich Plasma And *Administration of Anesthesia*

A. CONSENT FOR PROCEDURE (PRP Orgasm Enhancement)

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 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 and where delay might impair my health.

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

2. I understand the proposed procedure(s) to be: vaginal submucosal/suburethral, clitoral, and labial, PRP (platelet rich plasma) injection (PRP Orgasm Enhancement)

3. I understand the risks associated with the proposed procedure(s) to be:
   Bleeding
   No effect at all
   Constant awareness of the G-Spot and O-Spot
   A sensation of always being sexually aroused
   Constant vaginal wetness
   Mental preoccupation of the G-Spot and O-Spot
   Alteration of the function of the G-Spot and O-Spot
   Sexual function alteration
   Hematoma or bruising
   Hematuria (blood in urine)
   Alteration of vaginal sensations (usually with more intense pleasure)
   Hypersexuality (over active sex drive)
   Alteration of the female sexual response cycle
   Varied results
   Sex life alteration

4. I also understand that there may be other RISKS, 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 the alternatives to the proposed procedures and the related risks to be: do nothing.

B. 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, and allergic reaction(s) to medications and seizures from lidocaine.

C. 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.

_____ _____

Signature of Patient Date

_____

Patient Name (Printed)

D. PHYSICIAN ATTESTATION

I have explained the procedure(s), alternative(s) and risks to the person or persons whose signature is affixed above. The patient has verbally communicated to me that they understand the contents of this form.

_____ _____

Signature of Physician or Designee Obtaining Consent Date

E. INTERPRETER ATTESTATION (when applicable)

I have provided translation to the person(s) whose signature(s) is affixed above.

_____ _____

Signature of Interpreter Date