

CONSENT FOR THE PRIAPUS SHOT™ TREATMENT

A. Purpose

Using blood-derived growth factors (platelet rich fibrin matrix [PRFM]), the Priapus Shot is a safe procedure for enlarging and strengthening the penis.

B. Benefits

This treatment is natural in that your own cells are used, treated with a chemical that is not foreign to the body, and injected into the specified areas. Since a distillate of growth factors from your own blood (PRFM) is used, there should be no side effects from the material injected. The body reacts to the treated cells as it does to a wound and immediately starts repairing the tissue. This builds the underlying tissue with a possible (but not guaranteed) 10 to 20% increase in length and girth. You should see improvements immediately, although there is usually a return to prior treatment status in 3-5 days as the water is absorbed and prior to the complete action of the fibroblasts to increase the size of the penis. Within 2-4 weeks an increase in girth and length is common. There's actual growth of new tissue by stimulation of uni-potent stem cells, so the change in shape is not from something foreign being in the body but from the body actually rejuvenating and growing. The PRFM stimulates new blood flow with new blood vessels (neovascularization).

The results of this treatment commonly lasts 15 – 18 months but do not last as long in some people. A summary of results include the following:

Immediately larger, Strengthens the penis, Straightens the penis, Increased circulation within the penis for a healthier organ, Makes other therapies work better (if you still need Viagra or Cialis, then it will work better for you), Increases sensation and pleasure (helps correct the damage from diabetes), Increased size by design (Can place more in base or in the head or wherever makes for best result), No allergic reactions (using your own body's fluids), No lumpiness, and Minimal pain (no burning from the PRFM since it's from your own body).

C. Treatment

You may take a pain medication, such as Tylenol™ or a prescription medication may be requested. You may ask for an anti-anxiety medication to use prior to the treatment.

A numbing lidocaine cream is applied to the penis. Approximately 10 cc (about 2 tablespoons) of blood are drawn in the same way blood samples are taken for routine lab tests. The tubes of blood are centrifuged to separate the component cells. One type of cells is separated and used for this procedure. The cells are treated with calcium chloride which tricks the cells into thinking that they are in the body and the body has been injured. The platelets release growth factors into the liquid of the tube. The liquid is transferred into a syringe and injected into the penis using a tiny needle and in a way that distributes the growth factors in the proper way.

E. Foreseeable risks and discomforts

The primary risks and discomforts are related to the blood draw where there is a slight pinch to insert the needle for collection and there is a potential for bruising at the site. The injections at the treatment locations will feel about like a regular shot (a small needle is used). There is a potential for a small bruise at the injection sites. The risk of scarring is very minimal (about 10% of patients who use tri-mix injections weekly have scarring). There may be other risks not yet known with the use of PRP in the penis.

Smokers have less positive response to this treatment than non-smokers. There may be some variation in achieving the results requested as every man’s body type is different and may have a slightly different response.

F. Post-treatment

Just like muscle enhancement occurs best when hormonal therapies are combined with physical exercise, the results will be improved by physical therapies as outlined by Dr. _____ at the time of treatment.

G. Follow-up

Dr. _____ will follow-up with you to check on your progress and answer any questions.

You may call him to report on your progress or ask questions. He can be reached at (phone)_____.

H. Privacy.

Your privacy is protected as described in our office Privacy Act Document. PHOTOGRAPHS . I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand my identity will be protected.

I. Payment

I understand this is a cosmetic procedure and that payment is my responsibility. I have read the above and understand it. My questions have been answered satisfactorily by the doctor and staff. I accept the risks and complications of the procedure. I acknowledge that I have been offered a copy of the office Privacy Act Document.

Name (Printed)

Signed /Date

Witness/Date