# CONSENT FOR THE PRIAPUS SHOT™ (P-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 form the body actually rejuvenating and growing. The PRFM stimulates new blood flow the new blood vessels (neovascularization).
The results of the treatment commonly lasts 15-18 months but do not last as long in some people. A summary of results includes 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 be placed more in base or in the glans (head) or wherever makes for best result), no allergic reaction (using your own body's fluids), no lumpiness and minimal pain (no burning form the PRFM since its from your own body).

**C. TREATMENT**

You may take pain medication such as Tylenol™ before your treatment. You may ask for anti-anxiety medication to use prior to treatment (you will require someone to drive you to and from the appointment if taking an anti-anxiety medication).

A numbing lidocaine cream is applied to the penis. Approximately 10mL (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 cell is separated and used for this procedure. The cells are treated with calcium chloride which tricks the cells into thinking 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 in a way that distributes the growth factors in the proper way.

**D. FORESEEABLE RISKS AND DISCOMFORTS**

The primary risk and discomforts are related to the blood draw where there is a slight pinch to insert the need for collection and there is a potential for bruising at the site. The injections at the treatment locations will feel like a regular sot (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 patient's who use tri-mix injections weekly have scarring). There may be other risks not yet know with the same use of PRP in the penis. With use of topical or injected anesthesia there is a risk of Lidocaine toxicity and anesthesia reaction.

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.

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.

**E. "OFF-LABEL" USE**

I understand that the use of PRP 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 and the related risks to be: do nothing.

**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 HJ McHugh, APRN at the time of treatment.

**G. FOLLOW UP**

HJ McHugh will follow up with you to check on your progress and answer any questions.

You may call her to report on your progress or ask questions. She can be reached at 860 301 1321.

**H. PRIVACY**

Your privacy is protected as described in our Privacy Act Document. Photographs. I authorize the taking of clinical photographs and their use for scientific purpose both in publication sand presentations. I understand my identity will be protected.

**I. CONSENT FOR ANESTHESIA**

When local anesthesia and/or sedation is used by the physician/provider:
I consent to the administration of such local anesthetics as may be considered necessary by the physician/provider in charge of my care. I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures.

**J. 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 medical provider and staff. I accept the risk and complication of the procedure. I acknowledge that I have been offered a copy of the office Privacy Act Documentation.

**K. 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.

| _____ | _____ | _____ |
|---|---|---|
| Name (Printed) | Signature | Date |

**L. PHYSICIAN/PROVIDER 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 provider or designee obtaining consent | Date |