INFORMED CONSENT for IV AMNIOTIC DERIVED STEM CELLS

I, _____ have been advised and consulted about the injection technique of amnion and amniotic fluid derived stem cells for the treatment of neurological, musculoskeletal, inflammatory and autoimmune conditions. I understand and voluntarily consent and authorize the following procedure: intravenous injection of amnion and amniotic derived stem cells to possibly relieve pain, or improve function or reduce inflammation or the autoimmune activity in part. I understand the procedure may require follow up treatments.

Pre procedure diagnosis:

_____

I have been informed that even though this procedure is **not yet FDA approved**, it has been used safely and successfully on many other patients. We get our amniotic stem cells from the bonebank company (www.bonebank.com). The cells are gathered alive, then are frozen and shipped to us.

Goal of Injections: I have been advised that stem cell injection treatments are used in patients with various neurological, musculoskeletal, autoimmune and inflammatory conditions and that these patients may realize some improvement in their symptoms after iv injection of amniotic derived stem cells.

I have been advised that the procedure may initially increase the symptoms for one to three days (and occasionally, as long as ten days), and then may decrease in intensity, but may not completely eradicate my symptoms. I have been informed that the procedure has been used on many patients and has been proven safe.

_____I understand the hope is to alleviate symptoms but I acknowledge that **NO GUARANTEE** has been given by anyone as to the results that I may have.

_____ I have been informed that the alternatives to stem cell injections are: Surgical Intervention, medications, Injection and conventional treatments.

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

- Immediate pain at the injection sight
- Bruising
- Infections
- Nausea/vomiting
- Allergic reaction
- Dizziness or fainting
- Bleeding
- Itching at the injection site

_____ 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 am aware of the potential side effects explained.

Patient Signature Date

Surgeon's Signature Date