PATIENT CONSENT TO MEDICAL TREATMENT OR SURGICAL PROCEDURE AND

ACKNOWLEDGMENT OF RECEIPT OF MEDICAL INFORMATION

TO THE PATIENT: You have been told that you should consider medical treatment/surgery.

(1) the nature of your condition

(2) the general nature of the medical treatment/surgery

(3) the risks of the proposed treatment/surgery, as determined by your doctor

(4) reasonable therapeutic alternatives and material risks associated with such alternatives

(5) risks of no treatment.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the North Carolina law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible.

Please read the form carefully. Ask about anything you do not understand, and we will be pleased to explain.

1. **Patient name**: _____

2. **Treatment/procedure**: _____

(a) Description, nature of the treatment/procedure:

I. Exosome are nanovesicles derived from mesenchymal stems cells (MSCs). They work by generating signals that allow cells within the body to communicate with each and ultimately direct the body's response to inflammation, injury, and healing. MSC-derived exosomes contain a multitude of growth factors and regulatory molecules that allow for significant tissue repair and regenerative wellness. They do not contain cellular DNA, cannot replicate, have no metabolic activity, and are extensively tested to provide the highest safety profile and purity standards.

II. Indications for scar revision treatment include scars that are widened, raised, discolored, and/or tethered. However, the repair method and degree of improvement depend on the location, depth, size, and maturity of the scar. Ideal candidates are those with mature scars (scars older than 6 months) who do not smoke and can avoid direct sun exposure during the healing process.

(b) Purpose:

I. Reduced scar visibility

II. Improved functionality

III. Long-lasting results

3. Patient Condition: Scar revision

Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure or other therapy described in Item 2 is indicated and recommended:

4. Material risks of treatment procedures:

(a) All medical or surgical treatment involves risks. Listed below are those risks associated with this procedure that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed therapy. Please ask your physician if you would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or other associated risks that you might consider significant but may not be listed below.

I. Tumor formation*

II. Inappropriate stem cell migration and neurological complications**

III. Immune rejection of transplanted stem cells***

IV. Injection site irritation

V. Infection

VI. Pain and swelling at the injection site and micro needling site

(b) Risks generally associated with any surgical treatment/procedure, including anesthesia are: death, brain damage, disfiguring scars, quadriplegia (paralysis from neck down), paraplegia (paralysis from waist down), the loss or loss of function of any organ or limb, infection, bleeding, and pain.

ACKNOWLEDGMENT AUTHORIZATION AND CONSENT

(a) No Guarantees: All information given me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternate procedures or as to the prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either express or implied, as to the success or other results of the medical treatment or surgical procedure.

(b) Additional Information: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

(c) Particular Concerns: I have had an opportunity to disclose to and discuss with the physician providing such information, those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

(d) Questions: I have had an opportunity to ask, and I have asked, any questions I may have about the information in this document and any other questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner.

(e) Authorized Physician: The physician (or physician group) authorized to administer or perform the medical treatment, surgical procedures or other therapy described in item 2 is: **CIRCADIAN REJUVENATION**

CIRCADIAN REJUVENATION

(f) Physician Certification: I hereby certify that I have provided and explained the information set forth herein, including any attachment, and answered all questions of the patient, or the patient's representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

Signature of Physician (physician group): _____ Date/Time: _____

CONSENT

Consent: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his choice, to administer or perform the medical treatment or surgical procedure described in item 2 of this Consent Form, including any additional procedures or services as they may deem necessary or reasonable, including the administration of any general or regional

anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document, including any attachment, and all blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in item 2 of this consent form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

Witness: _____ Date/Time_____

Patient or Person authorized to consent: _____ Date/Time_____

If consent is signed by someone other than the patient, state the reason and relationship:

_____

_____

*Clinical studies on FVM tissue transplantation indicate that FVM cells when appropriately harvested rarely proliferate and form tumours after transplantation.

The significance of subarachnoid hemorrhage after penetrating craniocerebral injury: correlations with angiography and outcome in a civilian population.
Levy ML, Rezai A, Masri LS, Litofsky SN, Giannotta SL, Apuzzo ML, Weiss MH
Neurosurgery. 1993 Apr; 32(4):532-40.

**Mapping transplanted stem cell migration after a stroke: a serial, in vivo magnetic resonance imaging study.

Modo M, Mellodew K, Cash D, Fraser SE, Meade TJ, Price J, Williams SC
Neuroimage. 2004 Jan; 21(1):311-7.

***Circadian Rejuvenation does not use immunosuppressing compounds.