REMOVING Barriers

TRANSFORMATIVE TATTOO REMOVAL

Registration

CLIENT INFORMATION

Last Name:	First Name:	Middle Initial:	☐ Male ☐ Female ☐ Transgender ☐ Other: _____
Home Address:			Apt #:
City:	State:	Zip Code:	Date of Birth: / Age:
Home Phone:	Cell Phone:	Work Phone:	
Email Address:			

Living Arrangements:

☐ Both Parents ☐ Mother ☐ Father ☐ Grandparents
☐ Boy/Girl Friend ☐ Spouse ☐ Friend ☐ Group Home
☐ Foster Parents ☐ Shelter ☐ Self ☐ Sibling
☐ Does not have stable housing
☐ Detention Facility:_____
☐ Other:_____ ☐ Unknown

Ethnicity (select all that apply):

☐ Asian ☐ Latino
☐ Black ☐ Pacific Islander
☐ Cambodian ☐ Vietnamese
☐ White ☐ Other:_____
☐ Filipino ☐ Unknown

Total Household Size, Including Yourself (check one)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8+

Total Annual Household Income (estimated) _____

Do you rent or own your own home? ☐RENT ☐OWN

Are you a veteran? ☐YES ☐NO

Are you: ☐ Formally incarcerated ☐ Currently on probation ☐ Currently on parole

Do you have any of the following subsidized housing? Low-Income Housing Section 8

Are disabled or receiving disability? ☐ Yes ☐ No

Primary language(s):

Language(s) Spoken at Home:

EDUCATION

Please indicate highest level, school name, and last year attended:

Some HS, No Diploma/GED	Name: _____	Year:_____
GED	Name: _____	Year:_____
HS Diploma	Name: _____	Year:_____
Some College, No Degree	Name: _____	Year:_____
Post-Secondary Certificate	Name: _____	Year:_____
Associates Degree	Name: _____	Year:_____
Bachelor's Degree	Name: _____	Year:_____
Master's Degree	Name: _____	Year:_____
PhD	Name: _____	Year:_____

EMERGENCY CONTACT INFORMATION

Last Name:	First Name:	Relationship to you:	
Home Phone:	Cell Phone:	Work Phone:	Proficient in English? ☐Yes ☐No

REMOVING Barriers
TRANSFORMATIVE TATTOO REMOVAL

Consent and Rules of the Program

EMPLOYMENT INFORMATION

Are you currently employed? ☐ Yes ☐ No If yes, ☐ Part-time or ☐ Full-time

Current Job Title: _____ Current Employer: _____ Current Wage: _____

Income type: (select one) ☐ Hourly ☐ Weekly ☐ Yearly ☐ Contract

Is this position for which you receive benefits? ☐ Yes ☐ No If Yes, check all that apply

☐ Paid Time Off (sick leave or vacation) ☐ Health Insurance ☐ Dental and Vision Insurance

☐ Retirement (ex. 401k, IRA, Pension) ☐ Life Insurance ☐ Other (ex. vehicle/cellphone stipend)

Last employment date: _____

If not employed, how long have you been unemployed? Please circle one:

<5 weeks 5-14 weeks 15-26 weeks 27-51 weeks 52+ weeks Other: _____

Previous job title: _____ Previous Wage: _____

Previous Employer: _____ Type: FT PT

CLIENT NEEDS

Do you need childcare for any 2-5 year old children? ☐ Yes ☐ No Age(s): _____

Current Needs (mark all that apply):

☐ EDD Resources
☐ Childcare
☐ Computer Literacy

Which San Pablo EDC job training program(s) are you interested in? (mark all that apply):

☐ EBT/CalFresh/CalWORKs
☐ English Language Proficiency
☐ Financial Literacy
☐ Health Insurance
☐ High School/GED
☐ Housing
☐ Transportation
☐ Other Services: _____

☐ Career Technical Education
☐ Computer Literacy
☐ FLOW
☐ Moler Barber College
☐ Removing Barriers
☐ Richmond BUILD
☐ Stride Center
☐ Wardrobe for Opportunity
☐ Other: _____

TATTOO INFORMATION

Description	Location	Type of Ink used (if known	Amateur (A) or Professional (P)?	Is it a cover-up tattoo?

The previous data is gathered for program metrics only and will not be individually disclosed.

REMOVING Barriers
TRANSFORMATIVE TATTOO REMOVAL

Consent and Rules of the Program

MEDICAL HISTORY

There exists a risk if our staff is not aware of the general health and medical background of a client. This information may critically affect what procedure we may recommend or safely undertake. Please provide us with the following information and keep it updated.

Do you regularly use tanning salons or sun bathe? ☐Yes ☐No	If yes, how often:	Last time:

Do you have any of the following medical conditions? (check all that apply)

☐ Keloid Scarring ☐ Seizure disorder ☐ Thyroid imbalance ☐ Hormone imbalance ☐ Diabetes
☐ Skin disease/skin lesions ☐ Blood clotting abnormality ☐ Intestinal Ulcers/bleeding ☐ Any active infections ☐ Other (please list):

Are you currently under the care of a physician? ☐Yes ☐No	If yes, for what?

Female Patients: Is there any possibility that you may be pregnant at this time? ☐Yes ☐No
Are you breast feeding at this time? ☐Yes ☐No
Are you using contraception? ☐Yes ☐No

MEDICATIONS

What oral medications are you presently taking? ☐ Birth control pills ☐ Hormones ☐ Other (please list and reason for medication)

Are you on any mood altering or anti-depressant medication? ☐Yes ☐No	Do you take medications for a heart condition? ☐Yes ☐No
Have you ever used Accutane? ☐Yes ☐No	If yes, last time used:

What antibiotics do you use to treat infections?

What topical medications and creams are you currently using? ☐ Retin-A ☐ Other (please list and reason for meds)

ALLERGIES

Have you ever had an allergic reaction to any of the following? (check all that apply and describe reaction)

☐ Food:
☐ Latex:
☐ Antibiotics:
☐ Other medication:
☐ Other allergies:

When was your last treatment?	What area?

Do you have any discoloration in the area to be treated from tanning/sun or other? ☐Yes ☐No

Do you form thick or raised scars from cuts or burns? ☐Yes ☐No

Has there been scarring from any cause in the area(s) to be treated? ☐Yes ☐No	If yes, describe:

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? ☐Yes ☐No
If yes, describe:

*I certify that all of the medical, personal and skin history statements I have made on this form are true and correct. I am aware that it is my responsibility to inform the registration staff **and** treatment technician, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute treatment procedures.* _____ Initials

REFERRAL INFORMATION

How did you hear about the Removing Barriers Program?

☐ Friend:_____
☐ Parent/Guardian
☐ Probation
☐ Facebook
☐ Internet Search
☐ Agency:_____
☐ Other:_____
☐ Yelp
☐ Mailer/eblast
☐ SPEDC Website
☐ City of San Pablo Website
☐ New Skin Website

REMOVING Barriers
TRANSFORMATIVE TATTOO REMOVAL

Consent and Rules of the Program

PATIENT CONSENT/ASSIGNMENT

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform Removing Barriers of my current medical or health conditions and to update this history. A current medical history is essential for our physicians and staff to execute appropriate treatment procedures. I, the undersigned, understand that I am financially responsible for all charges. I understand that insurance carriers do not cover these services.

Print Name	Signature	Date

PRIVACY POLICY

I have received and/or read the (HIPAA) Notice of Privacy Practices. (Copies Available Upon Request.)

Print Name	Signature	Date

PHOTOGRAPH AUTHORIZATION & CONSENT

I, the undersigned, authorize Removing Barriers to take photographs of my tattoos before, during and after my treatments. My name will not be used unless I specifically agree that it may be used. I also understand that these photographs may be used for purposes including, but not limited to, educating future patients and in possible publications and promotions. I enter into this agreement willingly and hereby waive any right to compensation for such uses as Removing Barriers may determine.

☐ I allow San Pablo Economic Development Corporation to use my photographs for educational and marketing purposes

☐ I do not allow San Pablo Economic Development Corporation to use my photographs for educational and marketing purposes

Print Name	Signature	Date

REMOVING Barriers
TRANSFORMATIVE TATTOO REMOVAL

Consent and Rules of the Program

RELEASE AND ASSUMPTION OF RISK

I, **HEREBY RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE THE REMOVING BARRIERS PROGRAM, ITS EMPLOYEES, OFFICERS AND AGENTS** (hereinafter referred to as 'releasees') from all liability to the participant and undersigned, his or her personal representatives, assigns, heirs and next of kin for any loss, damage, or claim therefore on account of injury to the person or property of the undersigned, whether caused by any active or passive, reckless, gross or ordinary negligent act or omission of the releasees or otherwise while the undersigned is participating in the program.

The undersigned hereby agrees To **DEFEND, INDEMNIFY AND HOLD HARMLESS** the releasees from all liability, claims, demands, causes of action, charges, expenses, and attorney fees resulting from involvement in this activity whether caused by any negligent act or omission of the releasees, whether active or passive, gross or ordinary negligence, or otherwise.

I understand that accidents can occur during this activity. Knowing the risks of such activity, the undersigned hereby **ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE** while participating in the activity whether caused by any such negligent act or omission of releasees or otherwise. The undersigned expressly agrees that the foregoing release and waiver, indemnity agreement and assumption of risk are intended to be as broad and inclusive as permitted by California law.

I hereby give my **CONSENT** for my child to participate / **AGREE** to participate in the above activity and I execute this **RELEASE and WAIVER** on his or her behalf and on my own behalf.

Print Name	Signature	Date

REMOVING Barriers
TRANSFORMATIVE TATTOO REMOVAL

Consent and Rules of the Program

Please read and initial each item prior to first treatment

_____ I will not actively tan during the treatment process. If I go in the sun, I will apply sunscreen to the treated area (SPF 45 or higher) or cover the area.

_____ I understand Removing Barriers will not treat tattoos that are less than 6 months old and there is NO guarantee that 100% of the tattoo can be removed.

_____ I understand that laser tattoo removal can take several treatments. I know that it can range between 4-16 treatments. I also understand laser treatments fails to remove all pigment, especially from professional applied tattoos or deep amateur tattoos. It may not be effective on certain pigments such as yellows and may make a white tattoo darker. (Depending on location, type of ink, length of time, etc.)

_____ I know that I will be expected to wear protective eyewear during the procedure.

_____ I am 18 years of age or older.

_____ I understand that there may be changes to the treated area, such as skin texture, permanent lightening or darkening of skin, hair loss or thinning.

_____ I am aware that I may experience bruising post treatment.

_____ I am not allergic to red dye.

_____ I am aware that there is a risk of scarring (in particular raised scars) despite proper laser treatments.

_____ I understand that continued improvement can occur for several months after the treatment. (At times, you may be asked to skip a month, if determined by a registered nurse (RN).)

_____ I understand the clinic team does not use topical anesthesia. (Additional information can be given upon request.)

_____ I understand that I will need to cancel / reschedule my appointments 24 hours in advance to avoid a $10 fee.

_____ I understand that in some cases, laser treatments fails to remove all pigment, especially from professional applied tattoos or deep amateur tattoos. It may not be effective on certain pigments such as yellows and may make a white tattoo darker.

_____ I understand pictures will be taken to track my progress. If you refuse, please note :

_____ I will not wear red or blue attire (e.g., shoelaces, belts, hats, key chains, etc.). I understand that if I show up wearing such attire, I will be asked to remove it before entering the clinic.

_____ I will not wear any sports attire (e.g., 49ers, Raiders, Giants, etc.). I understand that if I show up wearing such attire, I will be asked to remove it before entering the clinic. Please ask Staff to for a loaner t-shirt if needed.

REMOVING Barriers
TRANSFORMATIVE TATTOO REMOVAL

Consent and Rules of the Program

_____ I understand I may have one companion with me at the clinic who is 18 years of age or older. I understand my companion must also abide by the rules regarding attire and respect of staff. I understand my companion is allowed in the treatment area with staff approval only. Other than my companion, I understand that there are no children, family members, or friends allowed in the clinic during clinic hours.

_____ I will not disrespect any staff members or anyone present at the clinic (raising voice, swearing, threatening comments or gestures, or actual physical harm).

_____ I will not say any negative comments about tattoo removal.

_____ I understand that if I request treatment be stopped once treatment begins, I will not be reimbursed for the clinic session.

_____ I understand there is a zero tolerance policy for rules violation.

_____ I understand that failure to follow the Rules of the Program will be grounds for instant termination and denial of future tattoo removal procedures.

By signing below, I am indicating that I have read, understand and agree to abide by the Rules of the Program.

_____	_____	_____
Print Name	Signature	Date

APPOINTMENT REMINDER CONSENT

This section refers to your monthly appointment reminders:

	YES	NO
May we phone, email, or send a text to you to confirm appointments?	☐	☐
May we leave a message on your answering machine at home or on your cell phone?	☐	☐
May we confirm appointments with members of your family?	☐	☐

Client Name: _____ Client Signature: _____
(PRINT NAME PLEASE

FOR REVIEW

Medical Director: _____ Date: _____