The Permian Basin Tattoo Removal Program

A community based program
in partnership with

The Midland/Odessa United States
Probation Office

and

Texas Tech
University
Heath Sciences Center
at the Permian Basin

The Permian Basin Tattoo Removal Program

Mission Statement:

The Program is designed to assist individuals and re-integrate into mainstream society by removing tattoos that would identify them as participating in or supporting anti-social behavior.

Permian Basin
Tattoo Removal Project

Mission:
This program is designed to assist individuals integrate and re-integrate into mainstream society by removing tattoos that would identify them as participating in or supporting anti-social behavior.

Target Audience:
Living in the Permian Basin area that agree to follow the guidelines of the program are welcome to participate. All youth under age 17 years must complete a parent/guardian permission form.

Program Guidelines:
Treatments will be conducted at the following location: 301North Avenue N, Midland, Texas 79701, once every month. (Typically the last Saturday of each month, unless a major holiday conflicts, i.e. Memorial Day or Christmas)

The guidelines for the program are as follows:

1. The program is voluntary.
2. All tattoos visible in normal street clothing are eligible for treatment and the participant must agree to have all visible tattoos removed.
3. If a participant acquires a new tattoo while participating in the Tattoo Removal Program, he/she will be ineligible for tattoo removal services.
4. Priority will be given to offenders with the following tattoos:
    a. Gang related
    b. Obscene
    c. Hinder ability to gain employment
    d. Anti-social in nature
5. If a participant misses two scheduled laser treatments he/she will be terminated from the program.
6. Tattoos may require more than one treatment; therefore, enrollment and completion of the program is ongoing.
7. Participants must participate in a tattoo removal orientation prior to actual removal of the tattoos.
8. Treatment will require a $50 administrative fee per session made payable by money order to ***Texas Tech University Health Science Center***.
9. Cancellations must be received by the Probation/Parole office 48 hours prior to your appointment.

For more information on PBRP, please contact your Parole/Probation Officer.

PATIENT INFORMATION

ALL INFORMATION REMAINS CONFIDENTIAL DATE: _____

PATIENT NAME (FIRST, MIDDLE, LAST): _____ SID: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PH: (____) _____ SOCIAL SECURITY #: _____

AGE: ____ DATE OF BIRTH: ____ / ____ / ____ SEX: ____ MARITAL STATUS: _____

CELL PHONE: (____) _____ DRIVER'S LICENSE: _____

OCCUPATION: _____ EMPLOYER: _____

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: (____) _____

IF MINOR, NAME OF RESPONSIBLE PARENT: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PH: (____) _____ BUSINESS PHONE: (____) _____

IN CASE OF EMERGENCY CONTACT:

NAME (FIRST, MIDDLE, LAST): _____ RELATIONSHIP: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: (____) _____ CELL PHONE: (____) _____

FAMILY DOCTOR/PRESENT ATTENDING PHYSICIAN:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

OFFICE PHONE: (____) _____

INSURANCE COMPANY NAME: _____

TATTOO TREATMENT
INFORMATION & CONSENT FORMS

I. The Infrared Coagulator (IRC) has been widely used in Europe for tattoo treatment, and recent in the United states. While these reports are all favorable with a low percentage of unsightly scars, infection, or pigment loss, results have not been analyzed from the patient's viewpoint.

All current methods of tattoo obliteration are costly, and have advantages and disadvantages. With all methods, including IRC, there will be some degree of skin scarring and other problems. **No tattoo can be removed without a trace! All tattoo treatments leave scars, and often must be repeated.** Current treatments include:

Salt abrasion	Skin graft
Dermabrasion	Over-tattooing
Surgical excision	Injections
Pulse laser/dye laser	IRC

The purpose of this study is to determine if results are acceptable in both amateur and professional tattoos using a less expensive device.

IRC was approved by the United States FDA for treatment of tattoos in 1991. Although healing of the skin above the tattoo often required 4 - 6 weeks, the quality of the healed areas are said to be comparable to laser treatments. The heat of IRC delivered into the skin was painful in some cases despite the use of local anesthesia. Ink that was visible after one treatment frequently dispersed during healing.

Blisters formed after each IRC treatment followed by crusts. Scars slowly lost red color over many months. Skin pigment (color) may be increased, decreased, or lost following any type of tattoo treatment!

II. HEALTH

My general health is (excellent good fair poor)
I am allergic to: _____ I am currently under a doctor's care for: _____

_____

I am currently taking the following prescribed medications: _____

_____

My last physical check up was: _____
I have been diagnosed as having diabetes, heart disease, arthritis, high blood pressure, (other): _____

_____

_____

I (have/have not) been treated for mental illness.
I (have/have not) had problems with anesthesia in the past.
I (have/have not) formed heavy, wide, or thick scars in the past.

III. My tattoo(s) were done in the year _____. The colors are _____
My tattoo(s) are (professional/amateur).
They are located: _____
Describe any previous attempts to "remove" or obliterate your tattoos:
_____
_____

TATTOO(S) INFORMATION:

Please provide information for each tattoo you wish to have removed:

Location	Date Obtained	Professional/Amateur	Describe any previous removal attempts if any

IV. By signing and initialing below, I give my permission for Texas Tech University Health Sciences Center and their staff to treat my tattoo or tattoos with the new and still unproven IRC method . I further agree to be photographed, and to furnish Texas Tech University Health Sciences Center with any information and my opinion of the procedure in the months to come.

1) I understand that I may have pain, blistering, and scars of some degree. _____
2) I am aware that two or more treatments may be required. _____
3) I am aware that I may be uncomfortable or dissatisfied with my scarring or other results of this IRC treatment. _____
4) I am aware that some tattoos cannot be completely obliterated. _____
5) I am aware that I must follow directions for aftercare, and return for an evaluation in sixty days or as instructed. (See Appendix A) _____
6) I am aware that there may be additional charges for subsequent treatments, if in the opinion of Texas Tech University Health Sciences Center, if the treatments are worth trying. _____
7) I am aware that certain areas of the body (back, chest, shoulder) are considered “Worst scar areas.” _____
8) I am aware that certain skin type people scar more than others, and that the degree of scarring or pigment change cannot be predicted. _____
9) I am aware of the risks and complications of surgery and skin treatments and understand the explanations of the procedure and risks that were explained to me. _____
10) I am aware that treatment of a tattoo by any method may leave the tattoo areas worse than before treatment. I accept this risk. _____
11) My questions have been answered to my satisfaction regarding treatment, results complications, etc. _____

_____ _____
Offender’s Name (print) Offender’s Signature

_____ _____
Parent/Legal Guardian (print) (only if under age 17) Parent/Legal Guardian Signature

_____ _____
Probation/Parole Officer (print) Probation/Parole Officer Signature

_____ _____
Witness (print) Witness Signature

TEXAS TECH UNIVERSITY HEALTH SCIENCE CENTER
Ambulatory Clinics

Patient Name/Medical Record #

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by TTUHSC physicians, employees and such associates, assistants, and other health care providers, as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand that TTUHSC is a teaching institution and I agree to be a part of the teaching programs. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this consent to treatment will be valid and remain in effect as long as I attend the TTUHSC Ambulatory Clinics unless revoked by me in writing with such written notice provided each clinic attended by me.

RELEASE OF INFORMATION: TTUHSC may disclose all or part of my medical record (including oral information) and may provide bills/invoices to: 1) any person, corporation or agency (or their authorized representative) which is or may be liable under a contract to TTUHSC, or to me or my family members for all or part of the clinic charges including, but not limited to, hospital or medical services companies, insurance or third-party payers, workers' compensation carriers, or my employer; and 2) any individual or entity designated by me as a guarantor or party responsible for payment of fees for health care services provided to me.

I understand and agree that the information I am authorizing to be released may include 1) AIDS/HIV test results, diagnosis, treatment and related information; 2) information about drug and alcohol use and treatment; and 3) mental health information.

I understand that I may revoke this authorization for the release of information at any time, by providing written notice to the Ambulatory Clinics, except to the extent that action has been taken in reliance on it. Unless earlier revoked, this authorization expires automatically ninety (90) days from the date signed or ninety (90) days after the last clinic visit or after all insurance or third party claims have been paid or satisfactorily resolved, whichever occurs last.

> **RELEASE FROM LIABILITY**: I release and agree to hold harmless TTUHSC and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand TTUHSC cannot be responsible for use or re-disclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me to TTUHSC physicians and/or Medical Practice Income Plan. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer and agree to make payment as requ3sted by TTUHSC.

I certify that this form has been fully explained to me, that I have read it or had it read to me*, and that I

understand its contents.

ADVANCE DIRECTIVE: I have signed an Advance Directive. _____ YES _____ NO
If yes, is it still in effect? _____ YES _____ NO; I have provided a signed copy to TTUHSC: _____ YES _____ NO

NOTICE OF PRIVACY PRACTICES:
I have received a paper copy of TTUHSC's Notice of Privacy. _____
(Patient's Initials)

_____ / _____
DATE TIME

_____ _____
Patient/Other Legally Authorized Person Witness/Translator*

_____ _____
Print Name and Relationship to Patient Print Name and Translated Language

TEXAS TECH UNIVERSITY HEALTH SCIENCE CENTER
Clinicas Amulatorias

Identificación del paciente
(DOB, MRN)

CONSENTIMIENTO PARA TRATAMIENTO MÉDICO: Volutariamente y con mi consentimiento acepto recibir servicios médicos por parte de los médicos de TTUHSC, según se considere necesario para el cuidado de mi salud. Yo entiendo que estos servicios pueden incluir diagnóstico, exámenes y tratamiento médico. Tengo claro conocimiento de que TTUHSC es una entidad educativa y por lo tanto estoy de acuerdo en participar en los programas educativos establecidos. Yo entiendo que no se me ha dado ninguna garantía sobre alivio o el resultado de mi tratamiento.

Yo entiendo que este consentimiento será valido y permanecerá vigente por el tiempo que se me preste atención médica en las Clínicas Ambulatorias de TTUHSC, a menos que yo revoque, por escrito, dicho permiso y este aviso sea enviado a cada clínica donde se me prestó atención médica.

AUTORIZACIÓN PARA REVELAR INFORMACIÓN DE SALUD PROTEGIDA: La información de salud protegida se refiere a sus diagnósticos y/o atención médica proporcionada por TTUHSC que incluye, pero no se limita, a información que se refiere a su salud mental (excepto apuntes de psicoterapia); información relacionada al tratamiento del abuso de alcohol y drogas; enfermedades contagiosas como virus de inmunodeficiencia o SIDA (Síndrome de inmunodeficiencia adquirida), resultados de pruebas de laboratorio, historial médico, notas de evolución en el tratamiento o cualquier otra información relacionada.

Al firmar este formulario, usted permite a TTUHSC usar o revelar informació de salud protegida que se refiere a su tratamiento, pago por el tratamiento, manejo de cuidado de su salud y otros asuntos según lo permita la ley. Nuestro Aviso de prácticas de privacidad le proporciona información acerca de cómo TTUHSC y sus empleados pueden usar y/o revelar información de salud protegida acerca de su tratamiento, pago por el tratamiento, manejo del cudado de su salud o por otros asuntos relacionados según lo permita y de acuerdo con la ley.

> **EXONERACIÓN DE RESPONSABLIDAD LEGAL**: Yo acepto exonerar a TTUHSC de toda responsabilidad junto con sus agentes, representantes y empleados por revelar la información confidencial estipulada en este documento. También estoy de acuerdo en que TTUHSC no debe ser considerado responsable por el uso y declarciones de información por parte de terceras personas.

RESPONSABILIDAD FINANCIERA Y TRASPASO DE BENEFICIOS: En consideración por haber recibido servicios médicos en esta institución, y por este medio, yo traspaso mis derechos, título, e intereses en todos los reclamos que se hagan en nombre mío a la compañia de seguro médico, Medicare/Medicaid, y a terceras partes, por pagos de servicios médicos que en otra instancia serían pagados a mí, a los médicos de TTUHSC y/o al Departamento del Plan de Ingresos Médicos para recibir estos pagos. También doy autorización para que el pago sea directamente enviado a los médicos de TTUHSC y/o al Departamento de Plan de Ingresos Médicos. Certifico también que la inforamción que he proporcionado con relación a los pagadores terciarios incluyendo Medicare/Medicaid es correcta y verdadera.

Acepto pagar todos los gastos por servicios médicos que no hayan sido cubiertos por, o que excedan la cantidad estipulada por Medicare/Medicaid, mi compañia de seguro médico, o terceras partes, y acepto hacer pagos de acuerdo a las condiciones establecidas por TTUHSC.

Certifico que este documento me ha sido plenamente explicado, lo he leído, o me ha sido leído, y que entiendo su contenido.

Disposición por anticipado:
Yo he firmado una Disposición por anticipado. _____ SÍ _____ NO
Si su respuesta es sí, ¿esta vigente? _____ SÍ _____ NO; He proporcionado una copia firmada a TTUHSC: ___ SÍ ___ NO

Aviso de normas de privacidad:
Her recibido una copia del Aviso de prácticas de privacidad _____
(Iniciales del paciente)

FECHA	HORA	Paciente/otra persona legalmente autorizada
TESTIGO	Imprima su nombre	Imprima su nombre y parentesco con el paciente

CONSENT FOR PUBLICATION

By signing below, I give my permission for Texas Tech University Health Sciences Center/United States Probation Office/Texas Department of Criminal Justice/Midland County Community Services and Corrections Department/Ector County Community Services and Corrections Department to photograph my tattoos for purposes of publications associated with tattoo removal programs including but not limited to the Permian Basin Tattoo Removal Program.

Offender's Name (print)	Offender's Signature
Parent/Legal Guardian (print)	Parent/Legal Guardian Signature
Probation/Parole Officer (print)	Probation/Parole Officer Signature
Witness (print)	Witness Signature

Tattoo Removal Aftercare Instructions
Information Sheet for Participants

★ After 48 hours remove the nonstick pad. You may shower and clean area with mild soap and water, let dry and hour before applying antibiotic cream (Neosporin Cream) then re-apply nonstick dressing and pressure wrap. This should be done until treated area looks clean and healed, usually 10-20 days. DO NOT USE OINTMENT, MUST BE CREAM.

★ After the area looks dry and healed, then use Cortisone cream (which can be bought over the counter @ your local Walgreens, HEB pharmacy etc.) daily with a nonstick pad, followed by the pressure wrap. The pressure wrap should be worn at all times.

★ Treatment can be done every 30 days, please call 432-683-3250 in Midland or 432-368-3177 in Odessa to schedule your next appointment.

IT IS IMPORTANT THAT YOU FOLLOW THE ABOVE INSTRUCTIONS AS NOTED TO OBTAIN A GOOD RESULT AND TO PREVENT INFECTIONS.

Appendix A

PERMIAN BASIN
TATTOO REMOVAL PROJECT
PROBATION / PARDLE REFERRAL

(For agency use only)

Name of Agency: _____ Date: _____

Name of parole/probation officer: _____

Has criteria been met by the offender? Yes ☐ No ☐

Gang Affiliation: Yes ☐ No ☐

Name of Gang: _____

Affiliation verified by PO? Yes ☐ No ☐

Method of verification: _____

_____

Consent Forms signed: Yes ☐ No ☐

Appointment date: _____ Time: _____

Photographs attached: Yes ☐ No ☐

Is offender willing to be photographed: Yes ☐ No ☐

Does offender need transportation: Yes ☐ No ☐

Application approved by committee Members:

_____ Jennifer Kurtz
United States Probation Office

_____ Noelia Guevara
United States Probation Office

_____ Teresa Vasquez
Odessa TDCJ

_____ April Lohlar
Ector CSCD

_____ Allen Bell
Midland CSCD

_____ Bryan Furman
United States Probation Office

_____ Tremane Peel
Midland TDCJ