Arrivederci Tattoo

Pricing Guide

CONSULTATION – Determine client's suitability to procedure.

REJECTED CLIENT ---------- NO CHARGE

ACCEPTED CLIENT ----------NO CHARGE

IMMEDIATE PROCEDURE ---------- NO CHARGE

REMOVAL SITE – SIZE

UP TO A 1 X 1 INCH TREATMENT AREA ---------- $150.00 PER PROCEDURE

UP TO A 2 X 2 INCH TREATMENT AREA ---------- $250.00 PER PROCEDURE

UP TO A 3 X 3 INCH TREATMENT AREA ---------- $350.00 PER PROCEDURE

UP TO A 4 X 4 INCH TREATMENT AREA ---------- $450.00 PER PROCEDURE

MAXIMUM NUMBER OF TREATMENTS

IF CLIENT AGREES TO FOLLOW THE NECESSARY "LIGHTENING AND REMOVAL AFTERCARE INSTRUCTIONS" AND PURCHASE AND USE THE TATTOO VANISH AFTERCARE HEALING CREAM AS INSTRUCTED, THEN THE NUMBER OF TREATMENTS SHOULD BE **THREE (3)** TO NO MORE THAN **FIVE (5)** TREATMENTS FOR EACH TREATMENT AREA. HOWEVER, SINCE THE SUCCESS OF THE TREATMENTS IS DEPENDANT ON THE CLIENT STRICTLY FOLLOWING THE AFTERCARE INSTRUCTIONS, SKIN TYPE, LOCATION OF TATTOO AND "RE-INKED" TATTOOS; **REGARDLESS** IF MORE THAN FIVE (5) TREATMENTS ARE REQUIRED, THE PRICE WILL BE NO GREATER THAN **50%** OF THE ORIGINAL TREATMENT PRICE PER PROCEDURE.

REMOVAL SITE SIZE IS _____ AT $_____ PER PROCEDURE FOR THREE (3) TO A MAXIMUM OF FIVE (5) TREATMENTS. HOWEVER, IF NECESSARY THE PRICE WILL BE $_____ FOR ANY ADDITIONAL TREATMENTS OVER FIVE (5) FOR THE SAME TREATMENT AREA.

_____ _____

CLIENT SIGNATURE DATE

Arrivederci Tattoo

Client History and Treatment Plan

Date: ____/_____/____ Name: _____ Birth Date: ___/_____/___

Address:_____City_____State_____Zip_____

Phone: _____

E-Mail: _____ How Did You Hear About Us? _____

Occupation: _____ Physician: _____

Circle the number(s), if you now have or ever had any of the following:

1	Accutane within past 6 months	22	Herpes (cold sores)
2	Acne	23	High/Low Blood Pressure
3	Alcohol _____ per day	24	HIV/AIDS positive test
4	Allergies (any)	25	Hyper-pigment (darkened scars)
5	Anesthetic problems with dental work	26	Hypo-pigment (lightened scars)
6	Any medical implants	27	Keloid or Hypertrophy scars
7	Any type of heart disease/stroke	28	Pacemaker
8	Asthma	29	Physician's care for any medical condition
9	Autoimmune disorder	30	Plastic Surgery, previously or planned
10	Bleed/Bruise easily	31	Pregnant or nursing
11	Communicable Disease	32	Psoriasis
12	Depression treatments	33	Radiation or chemo-therapy treatment
13	Dermatitis	34	Rosacea
14	Diabetes	35	Seizure related condition
15	Drugs, prescription/recreational	36	Sensitive to petroleum-based products
16	Eczema	37	Skin Cancer
17	Faint or become dizzy	38	Smoke_____ per day
18	Healing minor wound problems	39	Sun tanned or use tanning bed
19	Hemophilia	40	Sun burn easily
20	Hepatitis/Jaundice	41	Vitiligo
21	Herbal supplements taken		

Anything circled, please explain in space below:

TREATMENT PLAN

Description of unwanted tattoo, size, color and location:

_____

_____

Reason for lightening or removal: _____

Amount of removal desired: _____

Tattoo procedure was first and last worked on:_____and_____

How many tattoo sessions were performed at this site? _____

List any adverse reactions experienced after the application of the unwanted tattoo including, but not limited to, infections, swelling and bleeding:

_____

When did the defects identify become evident? _____

List any corrective action or medical treatment explored or attempted prior to this

consultation: _____

TECHNICIAN AREA TO FILL OUT

_____

It is estimated that lightening and/or an attempt to remove the unwanted tattoo ink will take from _____ to _____ sessions, scheduled at least 6 to 8 weeks apart. Client agrees to not pursue other removal treatments during this attempt to lighten and/or remove this unwanted pigment.

Client will purchase after care cream at additional price of $35 and follow the written instructions for the aftercare. The client will contact the technician listed below first (1st) in the event of any questions or concerns following the lightening and/or removal attempts.

The client affirms they fully disclosed the entire relevant history of the unwanted tattoo.

By affixing my signature below, both client and technician have discussed the above client history form and treatment plan and both agree that the information is fully understood.

Patient/Client Signature: _____ Date: _____

Technician Signature: _____ Date: _____

Informed Consent
Lightening and/or Removal of **Pre-Existing Tattoo Ink**

The nature, method and all risks of the proposed tattoo ink lightening or removal procedure has been explained to me. I was given full opportunity to ask any questions.
_____ (Client Initials)

I understand that there may be a certain amount of discomfort or pain associated with the procedure. Other rarely occurring adverse side effects may include but are not limited to lightening or darkening, scarring, or infection of the skin.
_____ (Client Initials)

I clearly understand ALL THE RISKS involved and the likelihood of any adverse reactions to the procedure. Tattoo Vanish will work with you to help achieve the best results possible.
_____ (Client Initials)

I understand there are other medical options, including LASER, available for removal of ink or pigment. I have decided to decline those methods.
_____ (Client Initials)

I understand that several treatments may be needed in order to achieve my desired results; however, I understand that there is no guarantee or assurance as to the ultimate outcome or result of this procedure. I understand that GinaMarie Camoza, Arrivederci and Tattoo Vanish has a NO REFUND POLICY.
_____ (Client Initials)

I will not hold my technician, Tattoo Vanish® or any owners, employees or independent contractors of GinaMarie Camoza, Arrivederci Tattoo and/or Tattoo Vanish®, Inc., liable for any damages that may occur to my person.
_____ (Client Initials)

I understand that the complete removal of tattoos is difficult. As a result, I will not hold my technician, GinaMarie Camoza and/or this establishment responsible for any resultant failure to lighten or remove completely the unwanted ink.
_____ (Client Initials)

I agree to follow all instructions concerning the care of my tattoo removal procedure area, while healing. I agree that any complications, resulting from my negligence, is totally my responsibility.
_____ (Client Initials)

I understand that I will be given written instructions for post procedure care and follow-up.
_____ (Client Initials)

I agree to submit to before and after photographs and I give my permission to use such photographs for publication and/or for teaching purposes only upon signing an additional release form
_____ (Client Initials)

I understand all information listed above, have had all my questions answered and agree to all conditions and provisions of this document as evidenced by my signature below. I accept the risks for having this procedure done, and I voluntarily request that the tattoo lightening and removal procedure(s) are to be performed on me:
_____ (Client Initials)

Name (Print) _____(Sign) _____**Date** _____

COMMONLY USED MEDICATIONS THAT CAN THIN YOUR BLOOD AND CAUSE BLEEDING

ASPIRIN AND IBUPROFEN PROHIBITED 10 DAYS PRIOR TO PROCEDURE

NO PRESCRIPTION

4-Way-Cold Tablets
Advil
Aleve
Alka-Seltzer
Anacin Analgesic
Apidex
Arthritis Pain Formula
Ascriptin Tablets
Bayer Adult Aspirin
Bayer Children's Aspirin
BC Power
Cama Arthritis Tablets
Ecotrin Tablets
Empirin Aspirin
Excedrin
Fastin
Ionamin Capsules
Measurin Tablets
Momentum
Norwich Aspirin
Oby-cap
Oby-trim
Phentercot
Phentermine
Phentride
Pro-Forte
St. Joseph Aspirin
Teramine
Ursinus Inlay-Tabs
Vanquish
Pro-fast
Suprenza

PRESCRIPTION

Axotal
Butazolidin
Calciparine Inj
Clinoril
Coumadin
Easprin
Feldene
Fiogesic
Heparin Sodium Inj
Indocin
Indomethacin
Medrol
Mephyton
Motrin
Nalfon
Phentermine
Protamine Sulfate
Supac
Synalgos DC
Tenuate
Naprosyn
Rufen
Tolectin
Zorpin

SUPPLEMENTS

ANIT-GOUT

Lopurin
Zyloprim

PAIN MEDS

Ascriptin
Ascriptin with codeine
Darvon Compound
Emperin
Emperin with Codeine
Fiorinal
Mictrainin
Synalgos DC
Talwin Compund

HERBAL MEDICATION, WEIGHT LOSS MEDICATION AND SUPPLIMENTS PROHIBITED

** TYLENOL OK**

ANY MEDICATION THAT YOUR PHYSICIAN HAS PRESCRIBED CAN NOT BE STOPPED WITHOUT YOUR PHYSICIANS'S PERMISSION

The following are suggestions to help prevent bleeding during your procedure.

1. DO NOT SMOKE! Please stop smoking as much as possible as soon as your procedure is schedule. Smoking interferes with your healing process.

2. Absolutely NO Aspirin-Containing drugs or products such as: Ibuprofen, Motrin, Aleve and Non-Steroidal Anti-Inflammatory drugs, as soon as appointment is schedule. The use of these products can promote bleeding. The only pain medication that can be safety taken is Tylenol.

3. AVOID vitamin E. If you take a multivitamin, make sure there is no more than 200mg of vitamin E per day.

4. AVOID Taking many over the counter medications including herbal supplement, energy pills and diet pills.

5. AVOID consuming red wine, herbal drinks, and energy drinks.

6. If you are unsure of what is in the medications/prescriptions you are currently taking, please call our office to ask. Many medications contain blood thinners and may promote bleeding. Be sure to talk to your doctor before stopping any prescription medication.

If you have any other question or concerns, please call our office at (480)765-7077

Procedure Prep Do’s & Don'ts

The Following are suggestions to help prevent bleeding during your procedure.

1. DO NOT SMOKE! Please stop smoking as much as possible as soon as your procedure is schedule. Smoking interferes with your healing process.

2. Absolutely NO Aspirin-Containing drugs or products such as: Ibuprofen, Motrin, Aleve and Non-Steroidal Anti-Inflammatory drugs, as soon as appointment is schedule. The use of these products can promote bleeding. The only pain medication that can be safety taken is Tylenol.

3. AVOID Vitamin E. If you take a multivitamins make sure there is no more than 200mg of Vitamin E per day.

4. AVOID Taking many over the counter medications including herbal supplement, energy pills and diet pills.

5. AVOID consuming red wine, herbal drinks, and energy drinks.

6. If you are unsure of what is in the medications/prescriptions you are currently taking please call our office to ask. Many medications contain blood thinners and may promote bleeding. Be sure to talk to your doctor before stopping any prescription medication.

If you have any other question or concerns, please call our office at (480)765-7077

LIGHTENING AND REMOVAL AFTERCARE INSTRUCTIONS

1. Bandage (if needed) that is put on immediately after procedure is to be left on NO LONGER than 2-3 hours. Area must be open to air afterwards.

2. Keep treated area clean and dry (reverse of when the tattoo was received). Any moisture or wetness to the treated area can cause the area to become infected and/or cause the scab to come off too soon, which may lead to less than desirable results and scarring. This includes ANY physical activity that may cause exertion and/or sweating. Medical grade shower patches are available for purchase.

3. If the treated area is below elbow or knee, elevate 10 minutes every 2 hours for three days.

4. Nothing else is allowed in the treated area, such as but not limited to makeup and ointment until healing has taken place and the expected scab has come off without interference.

5. If the treated area comes in contact with clothing that causes irritation to the treated area, cover the area as necessary for minimum amounts of time with a non-stick (Telfa) gauze or dressing. The gauze must allow the skin to breath.

6. Do not try to pick or remove the scab prematurely, as this can cause scarring and less ink removal.

7. After the scab exfoliates naturally, the skin may appear pink for up to one (1) year following the removal process. Massage the area 2-3 times a day with Tattoo Vanish®Aftercare Healing Cream. Arrivederci Tattoo Aftercare Healing Cream is available for purchase to aid in the healing of the "new" skin that has formed.

8. Client takes full responsibility for following Aftercare Instructions and takes full responsibility if an infection or adverse reaction occurs. If this happens, it will affect the results. The technician can be of assistance and is recommended to be contacted for corrective action.

9. If an infection or adverse reaction occurs at the site of your treated area, contact our office. We will advise you if there is a problem to contact your personal physician for Treatment.

10. I understand all information listed above, have had my questions answered, and agree to all conditions and provisions of this document as evidenced by my signature below. I accept the risks for having this procedure completed.

_____	_____
Client Signature	**Date**
_____	_____
Witness	**Date**

Informed Consent For Pigment (Tattoo) Lightening/Removal Specifically **Related To Darker Skin Tones Only**

I_____ understand that as a result of my darker skin tone there may be added risk for scarring, hyper-pigmentation or hypo-pigmentation or other damage to the skin. I will not hold my technician, Arrivederci Tattoo or any owners, employees or independent contractors of Arrivederci Tattoo liable for any damages that may occur to my person. _____ (Client Initials)

I understand that several treatments may be needed in order to attempt to achieve my desired results. However, I understand that there is no guarantee or assurance as to the ultimate outcome or result of this procedure. I understand that once the procedure has been started, Arrivederci Tattoo has a **NO REFUND POLICY**. _____ (Client Initials)

I understand all information listed above and agree to all conditions and provisions of this document as evidenced by my signature below. I accept the risks for having this procedure done and I voluntarily request that the tattoo lighting and removal procedure(s) be performed on me:

Patient/Client _____ Date _____

Witness _____ Date _____

PHOTOGRAPH/VIDEO MODEL RELEASE FOR ADVERTISING PURPOSES

I, _____, on (date) _____ do hereby assign to GinaMarie Camoza, Arrivederci Tattoo and Tattoo Vanish® absolutely the copyright and/or the right to copyright such photography/video and the right of reproduction thereof, either wholly or in part, the unrestricted use thereof, in whatever manner you or your licensees or assignees may, in your or their absolute discretion, think fit for all and any advertising, medical teachings, or other purposes.

I AGREE-

_____ _____

Signature Date

*** OR ***

I DISAGREE-

_____ _____

Signature Date

HOLD HARMLESS AGREEMENT

IMPORTANT: RELEASE AND WAIVER OF LIABILITY AND INDEMNITY.

I,_____, hereby acknowledge and agree that as a patron, and customer of GinaMarie Camoza at Arrivederci Tattoo and Tattoo Vanish Method, LLC., it's premises, facility, services, and products, involves risks of injury to persons or property, including but not limited to those described below, and patron/customer assumes full responsibility for such risks. In consideration of being a patron/customer of

GinaMarie Camoza at Arrivederci Tattoo and Tattoo Vanish Method LLC., for any purpose including, but not limited to, tattoo removal services, observation, use of shop equipment, services, or participation in any way, patron/customer agrees to the following: Patron/Customer hereby releases and holds GinaMarie Camoza at Arrivederci Tattoo and Tattoo Vanish Method, LLC., its directors, officers, employees, independent contractors and agents harmless from all liability to any patron/customer, their children, personal representatives, assigns, heirs, and next of kin for any loss, damage, personal injury, deformity, death, and forever gives up any claims or demands therefore, on account of injury to patron/customer's person or property, including injury leading to disfigurement or death of patron/customer whether caused by the active or passive negligence of GinaMarie Camoza at Arrivederci Tattoo and Tattoo Vanish Method LLC., or otherwise, to the fullest extent permitted by law, while patron/customer are in, upon, or about the GinaMarie Camoza at Arrivederci Tattoo and Tattoo Vanish Method LLC., premises using or not using their services, facility, or equipment. _____(initials).

BY:_____ _____

EXPLAINED AND UNDERSTOOD DATE

PATRON/CUSTOMER

_____

ARRIVEDERCI TATTOO

REPRESENTATIVE

Arbitration Agreement

In the unlikely event of a dispute between me, the undersigned, Arrivederci Tattoo, their employees, Independent contractors, GinaMarie Camoza as a result of having received a Tattoo Removal procedure, I agree to submit the matter to binding arbitration before a neutral arbitrator selected by the parties. In the event the parties cannot agree on a particular arbitrator from a panel submitted by the American Arbitration Association, then a neutral arbitrator will be appointed by the American Arbitration Association.

I understand that in submitting to binding arbitration, I am giving up my right to trial by court or jury, the right to an appeal and strict rules of evidence applicable to a trial held in a court of law. I have been afforded the opportunity to consult an attorney concerning the impact of this agreement and have either done so or elected to proceed without such consultation.

_____ _____

Client Signature Date

_____ _____

Witness Date

Client Clinical Consultation

Date: _____Name: _____
Address: _____
Email Address: _____
Cell: _____Occupation: _____

Tattoo Description: _____

Tattoo Size: _____Price (per) session: _____

COMMENTS: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pictures Taken [ ] Before [ ] After

[ ] Deposit $_____ [ ] Balance Due $_____ [ ] Paid

Appointment Scheduled:
Date: _____

Time: _____

After Care Cream Offered and explained, (circle): Yes/No $35.00 per bottle, sold separately.

Treatment Record & Notes

First Name:	**Last Name:**
Age:	**B-Day:**
Ethnicity:	**Hair Color:**
Eye Color:	**Skin type:**

Tattoo Removal & CIT Collagen Induction Therapy	**PPC Cosmetic Tattoo**
Procedure:	**Procedure:**
Needles:	**Needles:**
Speed Level:	**Pigment Color:**
	Mixture:

Notes

Procedure Date / Session
