Beverly Medical Center
Dr. Beverly Goode-Kanawati D.O.
Board Certified Family Practice & Board Certified Emergency Medicine(ABPS)
6008 Creedmoor Road
Raleigh, NC 27612
BeverlyMedicalCenter.com
Phone 919-844-4552 e-mail info@beverlymedicalcenter.com Fax 919-844-4556

COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary. I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Beverly Goode-Kanawati, DO, Sandra Britt, ANP-C and all the staff at Beverly Medical Center are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure, and I give my express permission for Dr. Beverly Goode-Kanawati, DO, Sandra Britt, ANP-C and all the staff at Beverly Medical Center to proceed with the same.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before, during, and after my treatment/procedure may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure itself.

I have been given the option to defer my treatment/procedure to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure.

INFORMED CONSENT FOR COVID-19 RISK I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

_____

Patient or Person Authorized to Sign for Patient _____

Witness_____Date/Time_____

_____ I have been offered a copy of this consent form (patient's initials) _____

Practitioner: _____

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Female Testosterone/Estradiol Pellet Insertion Consent Form

Bio-identical hormone pellets are concentrated hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are made from soy and are FDA monitored but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

My birth control methods (please circle):

Abstinence ☐ Birth control pill ☐ Hysterectomy ☐ IUD ☐ Menopause ☐
Tubal Ligation ☐ Vasectomy ☐ Other: _____

CONSENT FOR TREATMENT:
I consent to the insertion of testosterone and/or estradiol pellets in my hip. l have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below.

Bleeding, bruising, swelling, infection, painful extrusion of pellets, hyper sexuality (overactive libido), and lack of effect (from lack or absorption). Increase in hair growth on the face, similar to premenopausal patterns, birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present, change in voice (which is reversible), clitoral enlargement (which is reversible), acne. Water retention (estradiol only). Increased growth of estrogen dependent tumors (endometrial cancer, breast cancer).

The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause uterine bleeding. Higher dose testosterone therapy may increase ones blood count (hemoglobin, hemtaocrit) and thereby thickening the blood. This issue can be diagnosed with a CBC (complete blood count) therefore a complete blood count should be done at least annually. This can be reversed by donating blood periodically according to your tests.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE:
Increased libido, energy, and sense of well-being. Increased muscle mass and strength and stamina.

Decreased frequency and severity of migraine headaches. Decrease in mood swings anxiety and irritability. Decreased weight. Decrease in risk or severity of diabetes. Decreased risk of heart disease. Decreased risk of Alzheimer's and dementia.

I understand that the pellets cannot be removed after insertion.

I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction by Dr. _____or _____ ANP-C.

I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future pellet insertions.

I have read and understand the above information. I understand the procedure, benefits, risks, and alternatives to the
"Implantation of Testosterone/ Estradiol Pellets " and testosterone and estrogen therapy.
I agree to allow Dr. Beverly Goode-Kanawati DO or Sandra Britt ANP-C to implant the testosterone and or testosterone/estradiol pellets.
I understand that the practitioners at Beverly Medical Center will not be assuming my healthcare.
I agree to hold Dr. Beverly Goode-Kanawati, Sandra Britt and Beverly Medical Center harmless for any complications that may occur.
I have discussed any questions or concerns with Dr. _____ or _____, ANP-C

I agree to follow up with my primary care physician for my routine medical care, annual physical exam and breast exam, mammogram and PAP smear.

I understand that payment is due in full at the time of service. I also understand that Beverly Medical Center does not participate in insurance and does not participate in the claim process.

_____
PATIENT NAME PRINT

_____ _____
PATIENT SIGNATURE DATE

_____
WITNESS or Practitioner NAME PRINT

_____ _____
WITNESS or Practitioner SIGNATURE DATE

Beverly Medical Center Fee Schedule

Dr. Beverly Goode-Kanawati

New Patient Comprehensive- Up to 90 minutes	$795.00
Follow Up Dr. Goode:	
15 minutes to 30 minutes	$160.00
31 minutes to 45 minutes	$244.00
46 minutes to 60 minutes	$325.00
61 minutes to 1 hour and 15 minutes	$399.00
1 hour and 16 minutes to 1 hour and 30 minutes	$458.00
1 hour and 31 minutes to 1 hour and 45 minutes	$565.00
1 hour and 46 minutes to 2 hours	$650.00
Each additional up to 15 minutes	$80.00

Sandy Britt Adult Nurse Practitioner

New Patient Comprehensive- Up to 90 minutes	$695.00
Follow Up Sandy Britt:	
15 minutes to 30 minutes	$150.00
31 minutes to 45 minutes	$230.00
46 minutes to 60 minutes	$285.00
61 minutes to 1 hour and 15 minutes	$355.00
1 hour and 16 minutes to 1 hour and 30 minutes	$425.00
1 hour and 31 minutes to 1 hour and 45 minutes	$495.00
1 hour and 46 minutes to 2 hours	$570.00
Each additional up to 15 minutes	$70.00

Established, After hours phone calls (Urgent)	$50.00
Established, After hours phone calls (Non-Urgent)	$75.00

All above prices reflect in-office visits and remote consults (phone or video)

PRP Treatment:

One Knee $395

Both Knees treated at the same time is $595

Shoulder $495

Trigger point injections will be $395 per region; additional areas done at the same time will be $95 per area

PRP Full Facial with injections and micro needling $995

- **Partial Facial** eyes to forehead $395
- **Partial Facial** chin to nose $395
- **Partial Facial** or neck and decollete $395
- **PRP for Hair Rejuvenation** $495 for a single treatment or package of 3 treatments for $1275 paid at the same time as the first treatment.

PRP Facial with micro needling and PRP Hair Combo before $1390 after $100 discount $1290

Hormone Pellets:

Initial screening appointment by phone 10-15 minutes	Complementary
Visit with practitioner for exam and ordering of lab testing	$175.00
Men's procedure (Includes 4 Pellets):	$695.00
Women's procedure:	$420.00
Each additional Pellet:	$29.00

IV Nutrition Consultation Plus Lab

Consultation with provider	$175.00

Pregnancy Monitoring of Thyroid and Nutrition $700

-See policy for more information

Office Letters and Forms $45

Prescription Refill Requests not faxed $15

Billing and Cancellation Policy

Billing fees are determined by the time spent with the practitioner regardless of the amount of time set aside for scheduling purposes. These fees apply to office visits, phone consultations, and video consultations. Fees are subject to change without individual notice. Visit fees are non-refundable under any circumstance.

1. Payment is expected at the time of service. Our staff will provide you with a superbill which you may submit to your insurance company for reimbursement. We do not send medical records to insurance companies. We do not send letters for authorizations to insurance companies. We have opted out of Medicare; therefore, no claims can be submitted to Medicare for our office or medical procedures.

A ***minimum*** notice of 72 hours is required for appointment cancellations. Failure to fulfill this requirement will result in a cancellation fee of $75.00.

I have read and agree to the above policy.

_____ _____

Signature of patient Date

_____

Printed name of patient

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BIO-IDENTICAL HORMONAL THERAPY
FEMALE TESTOSTERONE HORMONE
ACKNOWLEDGEMENT INSERTION FORM

Although this therapy has been approved for human use, there are few doctors who currently administer estradiol and testosterone pellets in the United States. I realize that this is not the usual and customary means of hormone replacement.

I understand that bio-identical hormonal Testosterone will be inserted under my skin to achieve a steady delivery of natural testosterone hormone into my blood system. Testosterone is also made by my body, though levels decrease with age and in certain medical conditions. I realize that testosterone can increase my energy, my libido, and increase my sense of well being.
I realize in the past male and female athletes have abused testosterone. When they took large quantities of synthetic testosterone, they may have incurred heart problems, elevated cholesterol, and other health problems. However, low dose, non oral, natural testosterone that is used in bio-identical hormonal therapy has NOT been associated with these problems.

As this procedure is often an expense not covered by insurance benefits, I understand payment is due in full at the time of service. I understand my insurance will be not be billed. We do not participate with any type of insurance.

My signature certifies, I have read the above acknowledgement. I have been encouraged to ask any questions regarding bio identical hormonal therapy. My questions have been answered to my satisfaction.

_____
PATIENT NAME PRINT

_____ _____
PATIENT SIGNATURE DATE

_____
WITNESS or Practitioner NAME PRINT

_____ _____
WITNESS or Practitioner SIGNATURE DATE

Disclosure/Liability Waiver

Beverly Medical Center – Bioidentical Hormone Replacement Program

While numerous safety measures are taken by our physicians and staff, incidental events may occur that are beyond the control of our physicians or staff. Within the medical community, there are opposing views with respect to the use of bioidentical hormonal replacement therapies. The use of bioidentical hormones does provide true medical benefit, and is being used at our center to lessen/treat non-life threatening symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bioidentical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from Beverly Medical Center, its staff, or treating providers for injury to you on account of involvement in the Bioidentical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this program.

_____

Signature of Patient Date

Print Name

Witness or Practitioner Signature Date

Witness or Practitioner Print Name

Maintenance of Preventative Medicine and Cancer Surveillance

A requirement for acceptance and continuation in the bioidentical hormone replacement program is adherence to routine cancer screening. You must have routine physical examinations and mammograms. Your signature below indicates that you will comply by obtaining the cancer screening from your primary care physician within three months of beginning the Bioidentical Hormone Replacement Therapy Program and then according to current screening guidelines, which can be obtained, and followed with, your primary care physician.

I accept all terms and conditions of this program.

_____

Signature of Patient Date

Print Name

Witness or Practitioner Signature Date

Witness or Practitioner Print Name

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Female Hormone Pellet Questionnaire

Name: _____
DOB: _____ Date: _____
Referred By: _____

1. How has your energy level been lately?
   - ❑ Low
   - ❑ Medium
   - ❑ High

2. How often do you exercise?
   - ❑ Everyday
   - ❑ Every other day
   - ❑ Once a week
   - ❑ Once a Month
   - ❑ Never

3. Have you noticed a decrease in muscle mass?
   - ❑ Yes
   - ❑ No

4. Have you gained weight in the past 3-6 months?
   - ❑ Yes. How much? _____
   - ❑ No

5. Are you experiencing hot flashes?
   - ❑ Yes
   - ❑ No

6. Are you experiencing short term memory loss?
   - ❑ Yes
   - ❑ No

7. Are you experiencing any night sweats?
   - ❑ Yes
   - ❑ No

8. Are you experiencing any symptoms of depression?
   - ❑ Yes

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- ❑ No

9. How many hours do you sleep each night?
   - ❑ 1-3 hours
   - ❑ 3-5 hours
   - ❑ 5-7 hours
   - ❑ 8+ hours

10. If you had to rate your sex drive from a scale of 1 – 10 what would it be? (10 being extremely active)

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Post Pellet Insertion Instructions

- Remove large tape or Band-Aid after 48 hours, leaving the steri-strips in place.
- If needed, re-apply Band-Aid over the wound for a few days to catch any drainage that might occur.
- Keep wound completely dry for 24 hours. After that, showering is OK. Avoid soaking in tubs, pools or baths for at least 3 days.
- Leave steri-strips on wound for 5-7 days. If they fall off before, just keep a Band-Aid on and put a little tension across the wound just to give extra support for healing good and tight.
- Avoid vigorous exercise for 72 hours to reduce the chance of bruising, drainage or infection, or delayed wound healing. Walking and easy stair climbing is fine. Avoid running, biking, volleyball, raquet games, aerobic exercises or yoga 3-4 days. It would be best to avoid heavy lifting, repetitive squatting, and extensive housecleaning, like vacuuming, for 3 days. Avoid massage therapy directly at pellet site for 6 months.
- A little redness, bruising and swelling for 3-4 days is normal. The area may be tender for 4-14 days.
- If you have significant redness, pain (without putting pressure on the wound), warmth, or pus from the wound, call as you might need an antibiotic. This happens rarely, but infection is always a possibility with any kind of minimally invasive procedure.
- Apply an ice pack for 8-10 minutes, twice daily on the day of pellet insertion.

NEXT STEPS

- 4-6 weeks after INITIAL pellet insertion- labs will be drawn and you will receive a phone call for results and follow-up.
- Subsequent labs are drawn every 3-4 months to ensure accurate dosing of upcoming pellets. These lab results will be reviewed with you at your pellet insertion appointment.
- If a suture was used to close the incision, please call our office (919) 844-4552 to schedule your suture removal appointment 1 week after insertion.