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

ANDROGEN DEFICIENCY IN THE AGING MALE (ADAM) QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____Date: _____

This questionnaire is designed to help you and your doctor identify if you may be experiencing symptoms of low testosterone. If you are, you may choose to discuss treatment options with your doctor.

Please check YES or NO	YES	NO
1. Do you have a decrease in libido (sex drive)?	☐	☐
2. Do you have lack of energy?	☐	☐
3. Do you have a decrease in strength and/or endurance?	☐	☐
4. Have you lost height?	☐	☐
5. Have you noticed a decreased “enjoyment of life”?	☐	☐
6. Are you sad and/or grumpy?	☐	☐
7. Are your erections less strong?	☐	☐
8. Have you noticed a recent deterioration in your ability to play sports?	☐	☐
9. Are you falling asleep after dinner?	☐	☐
10. Has there been deterioration in your work performance?	☐	☐

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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: _____

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/prostate screening. You must have routine physical examinations including a prostate examination and PSA testing. Your signature below indicates that you will comply by obtaining the cancer/prostate 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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TESTOSTERONE/TESTOSTERONE-ANASTROZOLE

PELLET INSERTION CONSENT FORM

Testosterone pellet implantation has been used for androgen replacement since 1940. Implants may be manufactured or compounded. A physician or nurse practitioner implants the pellets under the skin of the flank ("love handles") or upper gluteal area through a small incision using local anesthesia.

Complications may occur and may include, but are not limited to, extrusion of the pellet, bleeding, bruising, swelling, skin discoloration, scarring, acne and infection.
There may be discomfort following the procedure. An ice pack may be applied.
Pellets dissolve and are not removed. Pellets avoid the liver. There is not an increase in clotting factors or elevation of liver enzymes. Alternatives to testosterone implants include topical creams and gels, patches, lozenges or injections.

Testosterone does not cause prostate cancer, but may stimulate an undiagnosed prostate cancer. If your PSA is elevated, you will need written approval sent directly from your urologist or primary care physician prior to testosterone therapy. Testosterone may also increase the production of red blood cells. If the red blood count elevates above normal, you may donate blood or lower your dose or testosterone. Testosterone, delivered by pellet implantation decreases sperm production and testicular size, and may worsen sleep apnea. A few recent studies have suggested an increased risk of cardio-vascular events in men receiving testosterone therapy, particularly in men with a history of heart disease.

In June 2014, the FDA issued a warning about increased blood clots in veins.
CONSENT FOR TREATMENT: I HAVE BEEN INFORMED THAT I MAY EXPERIENCE ANY OF THE COMPLICATIONS TO THIS PROCEDURE AS DESCRIBED BELOW.

Bleeding, bruising, swelling, infection and pain, lack of effect (typically from lack of absorption), thinning hair, male pattern baldness, increased growth of prostate and prostate tumors, extrusion of pellets, and hyper sexuality (overactive libido).
There can be 10-15% shrinkage in testicle size. There can also be a significant reduction in sperm production.
Testosterone is the major substrate or "building block" for estrogen. Symptoms of excess estrogen include fluid retention, bloating, breast tenderness, irritability and weight gain. You may be treated with an estrogen blocker, anastrozole, which can be combined with testosterone in the compounded pellet implant. Testosterone and estrogen levels may be checked to assess the absorption of testosterone and the conversion to estrogen.

• If there is a concern about prostate cancer, you will need written approval sent directly from your urologist or primary care physician prior to testosterone therapy. If approved you may elect a 3-4 month trial of treatment with a shorter acting testosterone preparation (gel, patch, shot). If the PSA is elevated, pellets may be implanted after a negative prostate biopsy and clearance by your urologist. Pellets are not removed.

• Notify the doctor if you are diabetic and have had a joint replacement.

• You must notify the physician of any allergies or bleeding problems prior to the procedure including anti-coagulant (Coumadin, Warfarin, Plavix, Eliquis, Pradaxa, Xarelto) or aspirin therapy.

• You should notify your primary health care provider that you have the testosterone implants and need follow-up care, including and annual CBC (blood count).

• If PSA increases on testosterone therapy, you must see your doctor or a urologist.

• You should avoid vigorous physical activity for 5 days following the insertion of the pellets.

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. I further acknowledge that there may be risks of testosterone therapy that we do not yet know, at this time, and the risks and benefits of this treatment have been explained to me. 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/Testosterone-anastrozole Pellets" and testosterone therapy.
I agree to allow Dr. Beverly Goode-Kanawati DO or Sandra Britt ANP-C to implant the testosterone and testosterone-anastrozole 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 prostate exam.

_____
PATIENT NAME PRINT

_____ _____
PATIENT SIGNATURE DATE

_____
WITNESS or Practitioner NAME PRINT

_____ _____
WITNESS or Practitioner SIGNATURE DATE

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MALE TESTOSTERONE PELLET INSERTION ACKNOWLEDGEMENT FORM

Although this therapy has been approved for human use, there are a few doctors who currently administer Testosterone pellets in the United States. I realize that this is not the usual and customary means of prescribing testosterone. I realize that the advantages of testosterone may include:

A) behavioral changes including decreasing depression, decreasing anxiety, and irritability, increasing energy and motivation, stabilizing mood, allowing one to cope better, improving one's self image, and enhancing one's stamina,

B) Improvement in one's cognitive functions (no longer operating "in a fog"), improving short term memory and allowing one to stay focused on a task.

C) physical effects such as decreasing total body fat, increasing lean body mass, and increasing bone density and muscle mass

D) sexual benefits such as increased libido, increasing early morning erections, increased firmness and duration of erections.

I realize there are potential concerns with testosterone therapy that may include the possibility of enhancing the current prostate cancer to grow more rapidly, for this reason a rectal exam and prostate specific antigen blood test is to be done before starting testosterone and must be done each year thereafter.

The second concern regarding testosterone therapy is that it may increase one's hemoglobin and hematocrit - or "thicken one's blood". This can be reversed through donating blood periodically. This problem can be diagnosed with a blood test. Thus, a complete blood should be done at least annually.

The final concern, especially in younger men, is that testosterone administration may suppress the development of sperm. The sperm count could dramatically reduce while a person is on testosterone therapy. However, this appears to be a reversible process in which the sperm count may be restored once the testosterone is discontinued. We encourage any man who is concerned with his fertility in the future to have semen analysis prior to initiation of testosterone therapy. Testosterone administration is **NOT TO BE USED** as a form of male contraception.

My signature certifies I have read and agree to the above. I have been encouraged to ask any questions regarding testosterone pellets. My questions have been answered to my satisfaction.

_____
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