Arlington Office

Physician's Weight Control and Wellness Centers

MEDICATION REFILL AUTHORIZATION

ALLOW ONE WEEK FOR PROCESSING
Please plan ahead so you do not run out of medication.

After completion this form can be mailed to: Physician's Weight Control Centers ATTN: MRA Form
716 Lincoln Square Arlington, TX 76011

Faxed to: 817-277-9309

Email to: Arlington@DrWeightControl.com (do NOT email to info@drweightcontrol.com)

Please Print

TODAY'S DATE: ______________________ **DATE OF LAST VISIT:**____________________

Name:____ **Date of Birth** ______________________

Mailing Address _____________________________________ **Home Phone** (_____)_______________

_____________________________________ **Work/Mobile** (_____)_______________

Current Weight: _____________ **Weight Last Visit:** _____________

Briefly describe your eating and exercise habits during the past month. ________________________________

____

Have your medications been effective? Please explain. ____

Any side effects from your medications? ____

PHARMACY INFORMATION - PLEASE NOTE: if you fax or mail in your MRA your prescription will be faxed or called in to your pharmacy. Your in-house supplements will be mailed to you.

Name of Pharmacy_____________________________ **Pharmacy Phone #** (______)_________________

Pharmacy Fax # (_____)________________________

Would you like your in-house supplements mailed to the above address? ☐ **Yes** ☐ **No**

PAYMENT OPTIONS (your cost will be $90.00 for a 4-week supply of medication)

1. You may mail money order made payable to Physician's Weight Control Centers along with your completed MRA form to the office (address below). Checks will not be accepted.
2. You may pay with a Credit Card (MRA's cannot be paid with a Debit Card)

PLEASE CIRCLE TYPE OF CARD MasterCard VISA Discover American Express

Card Number _______________________________________ Expiration Date __________________

CVV2 (3 digit code located on the back of your card) _________ Billing Zip Code _________________

Do you want a receipt mailed to you? ☐ **Yes** ☐ **No**

SIGNATURE ____

By signing, you are giving permission to Physician's Weight Control Centers to charge your credit card the amount of $90.00.

Otto Puempel. D.O. **Christopher Puempel, M.D**
Dale Allen, M.D. **Lindsey Britten, MPAS, PA-C**
Patrick Kirlin, D.O.