PHYSICIANS
weight control & wellness

WEIGHT and HORMONE REFILL AUTHORIZATION

Please Print

TODAY'S DATE: _____ DATE OF LAST VISIT: _____

Name: _____ Date of Birth _____

Mailing Address _____

Home Phone (_____) _____ Work/Mobile (_____) _____

Current Weight: _____ Weight at Last Visit: _____

Complete this section for your Bio-Identical Hormone refill request – answer all questions.

Any change in medication since you were last in the office _____Yes _____ No

If yes, list all changes_____

Have you had any adverse effects with your bio-identical hormone therapy _____Yes _____ No

_____ Headaches _____Irritability _____Mood swings _____Increased acne _____Difficulty sleeping

_____Itching at application site _____Breast tenderness _____Facial hair growth

Other_____

Have you noticed any improvement in the way you feel using bio-identical hormone therapy _____Yes _____No

Briefly describe improvements _____

Any other information or feelings you would like to list at this time? _____Yes _____No

If yes, briefly describe_____

Complete this section for your Weight Control refill request – answer all questions

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

_____

Have your medications been effective? Please explain.

_____

Any side effects from your medications?

_____

COMPOUNDING PHARMACY INFORMATION – *ALLOW UP TO ONE WEEK FOR PROCESSING*

Name of Pharmacy_____ Pharmacy Phone # (_____)_____

WEIGHT CONTROL PHARMACY INFORMATION *ALLOW UP TO ONE WEEK FOR PROCESSING*

Name of Pharmacy_____ Pharmacy Phone # (_____) _____

Would you like your in-house supplements mailed to the above address?

(As of January 1, 2021 a $5.00 shipping and handling fee will be applied to your total) ☐ **Yes** ☐ **No**

PAYMENT OPTIONS (your cost will be $150.00 for a 4-week supply of medication)

Payment by Credit Card (please circle) MasterCard VISA Discover American Express

Card Number _____ Expiration Date _____

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

You may also mail a **Money Order** made payable to Physician's Weight Control Center along with your completed Weight and Hormone MRA form to our office **(Checks and Debit Cards will not be accepted.)**

SIGNATURE _____

By signing, you are giving permission to Physician's Weight Control to charge your credit card the amount of $150.00 & a $5.00 s/h fee, if selected, you acknowledge that you have read and understand the MRA Guidelines and you agree to electronic transmission of prescriptions.

RETURN OPTIONS

Mailed to: PWCWC ATTN MRA 716 Lincoln Square, Arlington, TX 76011

Faxed to: 817-277-9309

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

NOTICE: *Because email is not secure, please be aware of associated risks of email transmission. Because you have chosen to communicate patient identifiable information by email, you are consenting to associated email risks. We cannot guarantee that information transmitted will remain confidential.*