PHYSICIAN'S weight control & wellness

Arlington Office
HORMONE REFILL AUTHORIZATION

ALLOW ONE WEEK FOR PROCESSING

Please Print

TODAY'S DATE: _____ DATE OF LAST VISIT:_____
Name:_____ Date of Birth _____
Mailing Address _____
Home Phone (_____)_____ Work/Mobile (_____)_____
Current Weight: _____ Weight Last Visit: _____

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 bioidentical 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
If yes, Briefly describe improvements _____

Any other information or feelings you would like to list at this time? _____Yes _____No
If yes, briefly describe:_____

COMPOUNDING PHARMACY INFORMATION - PLEASE NOTE: Your prescription will be sent electronically to your pharmacy. *(If you need changes to your hormones you may not use this form and will have to schedule with a Provider. Please plan ahead so you do not run out of medication.)*
Name of Pharmacy_____
Address: _____PharmacyPhone(_____)_____

PAYMENT OPTIONS: (your cost will be $110.00 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 Hormone MRA form to our office **(Checks and Debit Cards will not be accepted.)**

Do you want a receipt uploaded to your patient portal? ☐Yes ☐No

SIGNATURE _____

By signing, you are giving permission to Physician's Weight Control to charge your credit card the amount of $110.00, you acknowledge that you have read and understand the MRA Guidelines, and you agree to electronic transmission of prescriptions.

After completion, this form can be mailed to:
PWCWC - ATTN: MRA Form: 716 Lincoln Sq. Arlington, TX 76011
Faxed to: 817-277-9309
Emailed to: Arlington@drweightcontrol.com