

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)

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.

Please Print

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

Name: _____ **Date of Birth** _____

Mailing Address _____ **Home Phone** (____) _____

_____ **Work/Mobile** (____) _____

Current Weight: _____ **Weight Last Visit:** _____

LIST ANY AND ALL CHANGES TO YOUR MEDICAL HISTORY DURING THE PAST MONTH (new medications, illnesses, etc.) _____

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 called in to your pharmacy. Your in-house supplements will be mailed to you.

Name of Pharmacy _____ **Pharmacy Phone #** (____) _____

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, DO Christopher Puempel, MD Dale Allen, MD Patrick Kirlin, DO