Waco 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(_____)_____ Pharmacy Fax # (_____)_____

PAYMENT OPTIONS (your cost will be $105.00 for a 4-week supply of medication)
1. You may mail a Money Order made payable to Physician's Weight Control Center along with your completed Hormone MRA form to our office
2. You may pay with a Credit Card: If you are paying by credit card, please leave a contact number and we will call you to get your credit card information. DO NOT leave your credit card information on voice mail.
Phone number where we can reach you to get your credit card information (_____)_____.
(Checks and Debit Cards will not be accepted.)

SIGNATURE _____.
By signing you are giving permission to Physician's Weight Control Centers to charge your credit card the amount of $105.00.

After completion, this form can be mailed to:
PWCWC - ATTN: MRA Form: 2122 Austin Avenue Waco, TX 76701
Faxed to: 254-754-4354
Emailed to: Waco@DrWeightControl.com

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