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 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 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
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 ONE WEEK FOR PROCESSING

Name of Pharmacy_________________________ Pharmacy Phone # (______)__________________

WEIGHT CONTROL PHARMACY INFORMATION - ALLOW ONE WEEK FOR PROCESSING

Name of Pharmacy__________________________Pharmacy Phone # (______)__________________

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

(There is a $7.00 shipping and handling fee will be applied to your total) ☐Yes ☐No

PAYMENT OPTIONS (your cost will be $160.00 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 Weight and Hormone MRA form to our office.
2. You may pay with a 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 to charge your credit card the amount of $160.00 & a $7.00 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 Form : 2122 Austin Ave Waco,TX 76701
Faxed to: 254-754-4354
Email to: Waco@DrWeightControl.com

NOTICE: Because email is not secure, please be aware of associated risks of email transmission. If 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.