



MEDICATION REFILL AUTHORIZATION

ALLOW ONE WEEK FOR PROCESSING

Please plan ahead so you do not run out of medication.

Please Print

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

Name: _____ **Date of Birth** _____

Mailing Address _____

Phone (____) _____ Current Weight: _____ Weight at last visit _____

☐ Please check if the above address needs to be updated to the current address in your chart.

MEDICAL QUESTIONNAIRE:

List any and all changes to your medical history this month (new medications, illnesses, stressful events, 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:

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

Pharmacy Address _____ **City** _____ **Store#** _____

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

(As of March 1, 2026 a \$7.00 shipping and handling fee will be applied to your total)

☐ Yes ☐ No

PAYMENT OPTIONS:

*(As of March 1, 2026 your cost will be **\$120.00** for a 4-week supply of prescription medication)*

1. You may mail money orders made payable to Physician's Weight Control and Wellness along with your completed MRA form. Checks will not be accepted.

2. You may pay with a Credit Card (No Debit Cards) May also call the office with payment information.

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 _____

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.

SIGNATURE _____

By signing, you are giving permission to Physician's Weight Control to charge your credit card the amount of \$120.00 & 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.