



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.



PERMISSION TO CHARGE

www.drweightcontrol.com

716 Lincoln Square
Arlington, TX 76011
817-277-3469

Please print

Patient's Name: _____ Date of Birth: _____

has my permission to charge their office expenses with the Physician's Weight Control and Wellness to my:

☐ Credit Card ☐ Flex / HSA Card

Card Holder - a copy of your picture ID must be attached to this completed form.

Credit Card

Name on Credit Card _____ Billing ZIP Code _____

Relationship to Patient _____

Card Holder's day phone _____ Cell phone: _____

Type of card _____ Expiration date _____

CARD NUMBER: _____ Card Security Code _____

Flex / HSA Card Owner

Name on Flex / HSA Card _____ ZIP Code _____

Relationship to Patient _____

Card Holder's day phone _____ Cell phone: _____

Type of card _____ Expiration date _____

CARD NUMBER: _____ Card Security Code _____

I authorize Physician's Weight Control and Wellness to use my personal credit card or Flex card with the number above to pay charges and expenses for _____.

Patient's name

I understand my credit card information will remain on file electronically & indefinitely until I notify Physician's Weight Control and Wellness to no longer charge services to my card. _____.

Please initial

I authorize use of my card for New Patient cost of \$295.00

☐ YES ☐ NO

I authorize monthly office visit charges of \$120.00

☐ YES ☐ NO

I authorize payment of patient's No-Show Fee (\$25.00 per No-Show)

☐ YES ☐ NO

I authorize payment of patient's CPL lab charges of \$90.00

☐ YES ☐ NO

I authorize one-time transaction for \$_____ on ____/____/____

☐ YES ☐ NO

Card Holder - If for any reason you should dispute any charges from Physician's Weight Control and Wellness you will need to contact the patient and the patient will contact us personally to dispute any charges to your account. Any chargeback or retrieval fee will be forwarded to the above patient.

Signature of card holder: _____

NAME: _____ **DATE:** _____

NOTICE: You have chosen to communicate patient identifiable information electronically; you are consenting to associated risks. We cannot guarantee that information transmitted will remain confidential. In the event of a data breach the above patient will be notified.



www.DrWeightControl.com

Otto F Puempel, D.O.

Christopher L. Puempel, M. D

Physician's Weight Control and Wellness

716 Lincoln Square

Arlington, TX 76011

Phone: 817-277-3469

Fax: 817-277-9309

Request for Access to Patient's Health Information

As a patient of the Physician's Weight Control and Wellness, you are entitled under federal law to access your personal protected health information maintained in a "designated record set." In order to process your request for access to this information, please complete this form and submit to the Privacy Officer. When received by the Privacy Officer, he/she will use the information to verify your identity and process your request. If you have any questions or concerns, please contact the Privacy Officer, Christine Bowen at 817-277-3469.

Patient Information:

Patient Name _____ Birth Date _____

Address _____ Phone _____

I would like a copy of my protected health information:

- | | | |
|--|---|---|
| ☐ Records dated between _____ and _____ | | |
| ☐ Most current blood work | ☐ Most current EKG | ☐ All records |
| ☐ All blood work in record | ☐ All EKGs in record | ☐ Saliva results |

What is the reason you are requesting these records? _____

☐ Fax my records to: _____ Fax # _____

☐ I will pick up a copy of my records when they are ready.

☐ I would like to have a copy of my records mailed to the following physical address:

I understand that the Physician's Weight Control and Wellness is given thirty days to process my Request for Access if my information is maintained on-site and sixty days if the information is maintained off-site. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations.

By signing below, I acknowledge and agree to the above conditions.

Signature: _____ Date: _____

Note: This signed request is for this access/release only. You must complete another request form if you require additional information that is not within the records release dates you listed on this form.

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.*



No-Show Policy

The Physician's Weight Control & Wellness is dedicated to providing the highest quality care to our patients and we want to thank you for the privilege of being able to help you succeed in becoming a healthier you.

Recently we have been experiencing an increased number of patients who have either not shown up or called to cancel their appointment 24 hours before their appointment time. To correct this problem we have found it necessary to implement a No-Show Policy.

Read carefully. If you have questions about the guidelines of this Policy, please ask before signing.

No-Show Defined:

Failing to cancel your appointment at least 24 hours before appointment time in one of the following ways will be considered a NO SHOW.

1. Talking directly to someone on our staff
2. canceling by responding to your appointment email/text
3. calling and leaving a clear message (first and last name, date of birth, date and time of appointment) on our answering machine. (After hour cancelation messages may be left by calling 817-277-3469. All messages are recorded and kept.)

In addition, arriving up 15 minutes or more after your scheduled appointment time will be considered a no-show and will result in rescheduling. If you are stuck in traffic and trying to get to our office and find you will be a couple of minutes past the 15-minute deadline PLEASE CALL OUR OFFICE IMMEDIATELY. We will try to work with you to avoid a no-show for the day.

Our Policy:

If a NO SHOW by any of the above conditions apply, a \$25.00 no-show fee for that missed appointment will be assessed. The fee will be due when you come in for your next appointment or may be paid on our online portal. (If you have two consecutive no-show appointments you will not be able to schedule another appointment without first paying \$50.00 for the two missed appointments.)

We truly regret having to implement a policy such as this, but in fairness to our patients who are waiting for appointments, we need to take actions necessary to see that more have access to the medical care they need and want.

Thank you for understanding.

PWCW reserves the right to make changes to our No-Show Policy at any time. Should changes occur you will be notified and the new policy will be posted on our website.



Otto Puempel, D.O.
Christopher Puempel, M.D.
www.drweightcontrol.com

Medication Refill Authorization Guidelines

The Medication Refill Authorization (MRA) form is a request to have your medication filled without seeing the doctor or nurse practitioner (providers). **This form cannot be used until you are categorized as an established patient by a PWC provider.**

If you are experiencing any side effects from your medication, or the medication is not as effective as you think it should be, please do not fill out an MRA. You need to be seen by one of our providers. Medication changes are made during provider visits only. Changes cannot be made to your medication from your last office visit when using an MRA form.

MRAs can be submitted monthly, for three consecutive months (90 days), in-between office visits. You must complete a new form for each month.

Example: You complete an in-office appointment with one of our providers in June. You may submit an MRA form for July, August, and September. You will be required to see a provider again in October. A new form is required for each MRA appointment. Medication is written in a 4-week supply or for 28 days.

The cost of an in-office visit and a MRA are the same. MRAs are best not to be used as a substitute for an in-office visit. MRAs are designed for your convenience when circumstances arise that make it inconvenient for an in-office visit. Patients who come into the office for regular monthly visits with a provider tend to stick with their program better and reach their goals faster.

Your options with a MRA form are:

IN-OFFICE MRA – An appointment in the office for a weight/blood pressure check. You will receive your supplements and a Lipo B injection. You will not meet with a provider. Your information will be reviewed by a provider and your prescription will be sent electronically to the pharmacy of your choice after your appointment.

OUT of OFFICE MRA- the form is mailed or submitted electronically to our office. – An appointment is made on your behalf and reviewed by a provider. Once the form is approved your prescription will be sent electronically to the pharmacy of your choice. If you chose to include supplements those will be mailed to you with an additional fee for shipping. (*Note: Lipo B injections are not included with out of office appointments.)

Please be sure to completely fill out the form as incomplete forms will not be processed. If you choose not to include your credit card number on your form, please contact our office directly for alternative payment options.

While ease, convenience and adherence are the goals of the MRA, the health and safety of our patients is always our top priority. If at any time your health and safety are compromised, you will be required to see a provider.

IMPORTANT: Please allow at least a week for filling your MRA request. Do not wait until you are out of medication to submit your form. MRA forms are processed in the order they are received.