

## 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. In an effort to correct this problem we have found it necessary to follow the lead of other doctors offices and 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 by talking to someone on our staff, or calling and leaving a clear message (first and last name, date of birth, date and time of appointment) on our answering machine **at least 24 hours before your appointment time** to cancel your appointment will be considered a no-show. After hour cancelation messages may be left by calling 254-754-1438. All messages are recorded and kept. (Please do not send an email to [info@drweightcontrol.com](mailto:info@drweightcontrol.com) to cancel or change your appointment.)

**Showing 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 you miss your appointment without rescheduling at least 24 hours before the time of your appointment or if you are more than 15 minutes late you will be charged a \$25.00 no-show fee for that missed appointment. The fee will be due when you come in for your next appointment. (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 need to make an appointment and could have been scheduled at the time of a no-show patient, we need to take actions necessary to see that our appointments are open and available for our patients. Thank you for understanding.

***Physician's Weight Control and Wellness, Waco Office***

I have read and understand the No-Show Policy

Patients Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

***Yes, I would like to have a copy of this No-Show Policy*** \_\_\_\_\_

***No, I do not need a copy of this No-Show Policy (if no, please initial on the line)*** \_\_\_\_\_

PWCWC 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.

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**Office Use Only**

|                                                                   |
|-------------------------------------------------------------------|
| This no-show policy was reviewed with patient by _____<br>initial |
|-------------------------------------------------------------------|



**WACO OFFICE**  
**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 and Wellness ATTN: MRA Form 2122 Austin Av. Waco, TX 76701

**Faxed to:** 254-754-4354

**Email to:** Waco@DrWeightControl.com (do NOT email this form to info@drweightcontrol.com)

Please Print

TODAY'S DATE: \_\_\_\_\_ DATE OF LAST VISIT: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Current Weight: \_\_\_\_\_

LIST ANY AND ALL CHANGES TO YOUR MEDICAL HISTORY DURING THE PAST MONTH  
(including 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** - Your prescription will be called in to your pharmacy (allow one week for processing).

Name of Pharmacy \_\_\_\_\_

Pharmacy Phone # (\_\_\_\_\_) \_\_\_\_\_

Pharmacy Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Store # \_\_\_\_\_

Would you like our in-house supplements mailed to your home address? ☐ Yes ☐ No

(There is a \$7.00 shipping fee for mailed supplements)

**PAYMENT OPTIONS**

1. You may mail a money order made payable to Physician's Weight Control along with your completed MRA form to the Waco office. (address above). Your MRA cost will be \$120.00

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 (\_\_\_\_\_) \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_

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.



Otto Puempel, D.O.  
Christopher Puempel, M.D.  
[www.drweightcontrol.com](http://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.**

***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, Marty Brooks at 254-754-1438.

***Patient Information:***

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
\_\_\_\_\_ Cell 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 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.**

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