# Arlington Office

## Physician's Weight Control and Wellness

# 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 ATTN: MRA Form
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.*

***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*** (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 - PLEASE NOTE: if you fax or mail in your MRA your prescription will be called in to your pharmacy. Your in-house supplements will be mailed to you.**

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

**Pharmacy Address _____ City _____**

**Store #_____**

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

**PAYMENT OPTIONS (your cost will be $90.00 for a 4-week supply of medication)**

1. You may mail money order 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 (MRA's cannot be paid with a Debit Card)

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 _____

***Do you want a receipt mailed to you?*** ☐ **Yes** ☐ **No**

**SIGNATURE** _____

By signing,you are giving permission to Physician's Weight Control to charge your credit card the amount of $90.00.