Northwest Podiatric Laboratory **Account Update**

PRIMARY PRACTICE INFORMATION

Practice name: _____ Account # _____

Healthcare Professional licensed to prescribe:

Name: _____ Title: _____ Email: _____

Name: _____ Title: _____ Email: _____

Name: _____ Title: _____ Email: _____

Practice website: _____ Years/months in business: _____

Other contacts (e.g. Office Manager, Assistant, etc.)

Name: _____ Title: _____ Email: _____

Name: _____ Title: _____ Email: _____

What should appear on your orthotic label? (select one) ☐ Practice name ☐ Doctor name

BILLING

Federal Tax Identification Number: _____ PO Required? ☐ Yes ☐ No

Billing Address: _____ City: _____ State: _____ Zip: _____

Accounts Payable Contact: _____ Phone number: _____ ext. _____

Fax: _____ Email: _____ Send statements via: ☐ Email ☐ Mail

Type of Business: ☐ Corporation ☐ LLC ☐ Sole Proprietor ☐ Partnership

If Sole Proprietor or Partner, please list Business Owners: (If more partners to add, please list on separate sheet of paper)

Name: _____ SSN: _____ - _____ - _____

Home Address: _____

City: _____ State: _____ Zip: _____ DL#: _____ State: _____

Name: _____ SSN: _____ - _____ - _____

Home Address: _____

City: _____ State: _____ Zip: _____ DL#: _____ State: _____

SHIPPING

Preferred shipping method: ☐ UPS Ground ☐ UPS 2-day

UPS Ground shipping is recommended for doctors located in WA, OR, Northern ID, MT and Northern CA. UPS 2-Day shipping is recommended for doctors located in all other states.

☐ Same address as billing ☐ Different address than above (please complete below information)

Primary Practice: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax number: _____

ADDITIONAL PRACTICE LOCATIONS (if applicable). Please, specify primary practice location on Page 1.

Practice name (if different from Primary): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax number: _____

☐ Bill to primary practice address ☐ Bill to this practice address

Practice name (if different from Primary): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax number: _____

☐ Bill to primary practice address ☐ Bill to this practice address

PERSONAL GUARANTEE

The undersigned individual (the "Guarantor") personally and unconditionally guarantees prompt payment to Northwest Podiatric Laboratory, Inc. of any and all obligations owed by the Customer. This personal guaranty is a continuing and irrevocable guaranty of payment. Guarantor waives notice of default and nonpayment. Guarantor agrees to pay all costs, expenses and attorneys' fees incurred in enforcing this guaranty, including without limitation, fees and costs incurred in a bankruptcy proceeding, whether or not a lawsuit is filed. Guarantor consents to the personal jurisdiction of the courts of the State of Washington and agrees that venue may be placed in Whatcom County, Washington, at the option of Northwest Podiatric Laboratory, Inc. This personal guaranty is governed by Washington law. Guarantor consents to Northwest Podiatric Laboratory, Inc. obtaining a credit report on Guarantor for the purpose of evaluating his/her creditworthiness, in connection with an application for business credit.

Please sign and date to indicate you've read and agree to the above-stated terms:

Signature: _____ Print name: _____ Date: _____

TERMS

The undersigned, on behalf of the Customer, agrees to the following terms: Payment in full is due by the 25th of each month following the monthly billing period. Payment of a 1.5% per month service charge that is assessed to balances over 30 days past due. No discounts will be allowed on past due accounts. A 2% cash discount can be taken on all payments (excluding payment of Qk_prA_qr) received within 10 days of the statement date. No work will be processed for any account 60 days past due. An account reaching this status may be changed to COD status for future orders. Accounts are turned over for collection at 90 days past due, and will no longer be eligible for credit terms. The terms and conditions of the credit application take priority over any inconsistent terms contained in other customer provided documents. Payment of all costs, expenses and attorneys' fees incurred in enforcing these terms, including without limitation, fees and costs incurred in a bankruptcy proceeding, whether or not a lawsuit is filed. Consent to the personal jurisdiction of the courts of the State of Washington and agrees that venue may be placed in Whatcom County, Washington, at the option of Northwest Podiatric Laboratory, Inc. If a provision of the Agreement is or becomes illegal, invalid or unenforceable in any jurisdiction, that shall not affect the validity or enforceability in that jurisdiction or any other provision of this Agreement; or the validity or enforceability in other jurisdictions of that or any other provision of this Agreement. Failure to exercise, or any delay in exercising, any right or remedy provided under this agreement or by law shall not constitute a waiver of that or any other right or remedy, nor shall it preclude or restrict any further exercise of that or any other right or remedy. I hereby authorize Northwest Podiatric Laboratory, Inc. to contact the banks and suppliers listed on the new account application, or any credit bureau or other reporting agency, to obtain information needed to consider granting credit privileges.

Please sign and date to indicate you've read and agree to the above-stated terms:

Signature: _____ Print name: _____ Date: _____

☐ **Auto Pay with Credit Card or ACH prior to shipment**

☐ **Enroll in Auto Pay:** Complete Automatic Payment Authorization Form.
Payment processed on 10th of each month for statement balance less 2% discount.
*if payment declined, full statement balance owed.

Questions about this form or our terms? Please contact Accounts Receivable, via phone at 800-443-7260 or via email at ?P@nwpodiatric.com.
FAX COMPLETED FORMS TO 360-332-5306. We appreciate the opportunity to serve you and your patients.

Northwest Podiatric Laboratory **Automatic Payment Authorization**

Customer account number (if applicable): _____ **Practice/doctor name:** _____

Monthly statement amount on the 10th of each month.

Option #1: Electronic Check (ACH) *US Bank Accounts only

Bank name: _____

Routing #: _____

Account #: _____ ☐ Savings ☐ Checking

Option #2: Credit Card

Please enter your credit card details exactly as shown on your credit card billing statement.

Credit card type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Credit card #: _____ - _____ - _____ - _____

Expiration: _____ Security Code: _____

Company: _____

Name on card: _____

Billing address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Authorization

I authorize Northwest Podiatric Laboratory, Inc. to process my payment using the method selected:

Name of authorized signer (please print): _____

Signature: _____ Date: _____

This authorization can be stopped at any time by contacting Northwest Podiatric Laboratory at the address listed below.

Please complete and return this form to Account Receivable, via fax at 360-332-5306 or email at AR@nwpodiatric.com.