



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.**