Northwest Podiatric Laboratory **ACH/Credit Card Payment Account Form**

PRIMARY PRACTICE INFORMATION

Practice name: _____

Healthcare Professional licensed to prescribe:

Name: _____ Title: _____ Email: _____

Name: _____ Title: _____ Email: _____

(If additional names to add, please list on separate sheet of paper.)

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: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

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

Fax: _____ Email: _____

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

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 billing (please complete information below)

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax number: _____

(If additional locations, please list on separate sheet of paper.)

EST. NW 1964
PODIATRIC
LABORATORY

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.