



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.)



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.**