NWPL Account Application

EST. NW 1964 PODIATRIC LABORATORY

Practice Information

Practice Name: _____

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

Website: _____

Healthcare Professionals licensed to prescribe orthotics: (if necessary, add more on additional page)

Name	Email	Phone

Other Contacts (Office Manager, Receptionist, Medical Asst, Purchasing, etc.)

Name	Title	Email	Phone

Billing Information **Please enclose Sales and Use Tax Form (Required)*

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

PO Required: ☐ Yes ☐ No Send invoices via email: _____

Tax ID#: _____ Send Statement via email: _____

Accounts Payable Contact: _____ Phone Number: _____

Email: _____ Fax Number: _____

Shipping Information

Shipping Method: ☐ UPS Ground ☐ UPS 2nd Day

UPS Ground is recommended for Western States (1-3 days)
2ND Day is recommended for all Midwest/Eastern states for faster turnaround (Ground takes up to 5 business days)

☐ Same address as billing

Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Additional Office/Shipping location *(If any additional locations, add on additional page)*
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Billing / Payment Preference:

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 Number: - - -
Expiration: / Security Code:

Company:
Name on Card:
Billing address:
City: State: Zip:
Phone#:

Note: By signing this application, you acknowledge that you understand our terms for payment on invoices and that you agree to pay a 1.5% per month service charge that is assessed to balances over 30 days past due. No work will be processed for any account 60 days past due. Accounts are turned over for collection at 90 days past due and will no longer be eligible for credit terms.

Terms:

☐ No, I will pay prior to shipping with the above payment option. *(skip page 3)*

☐ Yes, I am applying for terms to be billed monthly. *(Page 3 is Required)*

- ☐ Yes, I would also like to be set up on the Auto Pay Program.
  Payment processed on the 10th of each month for the statement balance less 2% discount.
  **If payment declined, full statement balance owed.*
- ☐ No, I do not want to be set up on the Auto Pay Program.

Terms Note: Application must be submitted by owner/principal for credit consideration. The undersigned grants permission to Northwest Podiatric Laboratory, Inc. to access any credit information available on their company and/or principals to establish a credit account.

I authorize Northwest Podiatric Laboratory, Inc. to process my account application and process payments using the payment method selected above:

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 Accounts Receivable
Questions about this form or our terms?
Please contact Accounts Receivable, *via phone at 800-675-1766 or via email to AR@nwpodiatric.com*.

Confidential Credit Application

Business Name:

Years in Business:

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

Name, Title and address of Owner, Partner, or Corporate Officer:

Name: Title:
Street: State: Zip:
SSN:

Name: Title:
Street: State: Zip:
SSN:

Name: Title:
Street: State: Zip:
SSN:

Name: Title:
Street: State: Zip:
SSN:

Trade References:

Company Name	Contact Name	Phone	Email

Additional Practice Information – page 4

Additional Doctors/Healthcare Professionals

Name	Title	Email	Phone

Additional Office Contacts

Name	Title	Email	Phone

Additional Office Locations

Clinic Name:
Address: City: State: Zip:
Phone: Fax:

Clinic Name:
Address: City: State: Zip:
Phone: Fax:

Clinic Name:
Address: City: State: Zip:
Phone: Fax:

Clinic Name:
Address: City: State: Zip:
Phone: Fax: