NWPL ACCOUNT APPLICATION

PRACTICE INFORMATION

Practice Name: ______________________________

Healthcare Professionals licensed to prescribe orthotics: (If more than two, please see page 4.)

Name: ____________ Title: ____________ Email: ____________

Name: ____________ Title: ____________ Email: ____________

Practice website: ______________________________

Other contacts (Office Manager, Receptionist, Medical Asst, Billing, Ordering etc)

Name: ____________ Title: ____________ Email: ____________

Name: ____________ Title: ____________ Email: ____________

Name: ____________ Title: ____________ Email: ____________

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

BILLING INFORMATION *Please enclose Sales and Use Tax Form (Required)

Billing Address: ____________ City: ____________ State: ____ Zip: ________

PO Required? Yes No Blanket PO#: ____________ Send invoices via: Email Mail

Accounts Payable Contact: ____________ Send statements via: Email Mail

Phone number: ____________ Fax: ____________ Email: ____________

Business Type: Corporation LLC Sole Proprietor Partnership

If Sole Proprietor or Partner, please list Business Owners:

Name: ____________ SSN: ________ - ______ - ________

Address: ____________ City: ____________ State: ____ Zip: ____ DL#/State: ____________

Name: ____________ SSN: ________ - ______ - ________

Address: ____________ City: ____________ State: ____ Zip: ____ DL#/State: ____________

SHIPPING

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, please see page 4)

Address: ____________ City: ____________ State: ________ Zip: ________

Phone: ____________ Fax: ____________

BILLING/PAYMENT PREFERENCES:

TERMS (Apply for credit terms and be billed monthly)

PREPAY (Pay before shipment)

Auto Pay: Complete Automatic Payment Authorization Form. Payment processed on the 10th of each month for statement balance less 2% discount.

*If payment declined, full statement balance owed

VENDOR CREDIT REFERENCES

1. Company: ______________________ Contact name: ______________________

Account number: ______________________ Phone number: ______________________

Fax number: ______________________ Email address: ______________________

2. Company: ______________________ Contact name: ______________________

Account number: ______________________ Phone number: ______________________

Fax number: ______________________ Email address: ______________________

3. Company: ______________________ Contact name: ______________________

Account Number: ______________________ Phone number: ______________________

Fax number: ______________________ Email 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 SmartCast) 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: ____________

Questions about this form or our terms?
Please contact Accounts Receivable, via phone at 800-675-1766 or via email to AR@nwpodiatric.com.
FAX COMPLETED FORMS TO 360-332-5306. We appreciate the opportunity to serve you and your patients.

NWPL PAYMENT AUTHORIZATION

Practice/Doctor Name: ______________________________

TERMS: (Apply for credit terms and be billed monthly) **PREPAY:** (Pay before shipment) **AUTO PAY** Payment processed on the 10th of each month for statement balance less 2% discount.

*If payment declined, full statement balance owed.

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 ACCOUNTS RECEIVABLE, VIA FAX: 360-332-5306 OR EMAIL: AR@NWPODIATRIC.COM

ADDITIONAL PRACTICE INFORMATION

Additional Doctors/Healthcare professionals:

Name:______________________ Title:________________ Email:____________________________

Name:______________________ Title:________________ Email:____________________________

Name:______________________ Title:________________ Email:____________________________

Name:______________________ Title:________________ Email:____________________________

Additional Office Contacts:

Name:______________________ Title:________________ Email:____________________________

Name:______________________ Title:________________ Email:____________________________

Name:______________________ Title:________________ Email:____________________________

Name:______________________ Title:________________ Email:____________________________

Additional Office Locations:

Address: ___________________________ City: __________________ State: ______ Zip: __________

Phone: ______________________ Fax: ______________________

Address: ___________________________ City: __________________ State: ______ Zip: __________

Phone: ______________________ Fax: ______________________

Address: ___________________________ City: __________________ State: ______ Zip: __________

Phone: ______________________ Fax: ______________________