

# 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 Tax ID#: \_\_\_\_\_ 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](mailto: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.

Monthly statement amount on the 10th of each month.

\*If payment declined, full statement balance owed.

## 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: \_\_\_\_\_