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