

Feet Retreat, LLC
PO Box 7751
Bend, OR 97708



Phone 541.788.4785 **Fax** 541.312.5280
FeetRetreatBilling@gmail.com

www.OregonFeetRetreat.com

*Foot Care Clinics throughout
Central Oregon*

DAWN UNZE, RN
Foot Care Coordinator

PERMISSION TO PROVIDE FOOT CARE FOR RESIDENT

I give permission for _____, who is currently a
Patient Name
resident of _____, to receive Foot Care services.
Facility

Foot Care service includes:

- Foot soak
- Trimming & filing of toenails
- Inspection of feet, legs and toes
- Referrals to physician or podiatrist, if needed
- Complimentary fingernail trim, if needed

Services are provided by a Registered Nurse.

I understand that I am responsible to pay the fee for this service, which is currently billed at **\$45**, payable to **FEET RETREAT, LLC**.

\$5 discounts are available for: *prepaid accounts, payments rendered at time of service, and for accounts with an Auto Pay Authorization on file.*

Payment terms are Net 15 of invoice date and prompt payment is always appreciated.

Please acknowledge this responsibility by signing below and provide us with your billing information.

Authorized Signature

Date

Billing Name : _____

Billing Address : _____

City/State/Zip : _____ Phone : _____

If you would like invoices e-mailed to you, please indicate & provide below.

E-mail : _____

~ Thank you for putting your trust in us! ~

Feet Retreat, LLC
PO Box 7751
Bend, OR 97708



Phone 541.788.4785 **Fax** 541.312.5280
FeetRetreatBilling@gmail.com
www.OregonFeetRetreat.com

BILLING and PAYMENT OPTIONS

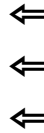
Our standard payment terms are due within 15 days of invoice. Printed invoices are sent by mail.

\$5 discounts are available for: *prepaid accounts, payments rendered at time of service, and for all accounts with an Auto Pay Authorization on file.*

Please use this form to:

- **Request e-mailed invoices** — Upon invoice receipt, you can opt to make a one-time online payment.
- Setup **recurring eCheck/Credit Card payments** to automatically deduct from your account when services are rendered. We'll send you a paid receipt.

To take advantage of these time-saving options, please complete and return to us via fax or mail.



Thank you!
The Billing Dept.
FEET RETREAT, LLC

YES! Please **e-mail** invoices/paid receipts to: _____
Please add us to your "trusted" contacts list.

YES! **AUTO PAY AUTHORIZATION**

I authorize **FEET RETREAT, LLC** to charge/debit the account below each time Foot Care services are provided for: _____

Patient Name and Facility

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Feet Retreat, LLC at least 15 days prior to the next foot care service date. For eCheck (ACH debits) to my checking/savings account, I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute the scheduled transactions with my bank or credit card company, provided the transactions correspond to the terms indicated in this authorization form.

▶ _____
Authorized Signature *Printed Name of Responsible Party / Relationship to Patient* *Date*

▶ _____
Mailing Address of Responsible Party (if different from below) *Phone*

Option 1 - eCheck (ACH debit): Personal Checking Personal Savings Business Checking



Bank Routing #: _____
Account #: _____

~~~~~  
Please attach a voided check  
~~~~~

Name on Account: _____

Address: _____

City/State/Zip: _____ **Phone:** _____

- OR -

Option 2 - Credit Card:

CARD #: _____ **Exp.** ____ / ____

Cardholder Name: _____

Billing Address: _____

City/State/Zip: _____

CVV SECURITY CODE: _____
Visa/MC/Disc = last 3 digits on back of card
AMEX = 4 digits on card face