Feet Retreat, LLC
PO Box 7751
Bend, OR 97708

www.OregonFeetRetreat.com

Phone 541.788.4785
Fax 541.312.5280

FeetRetreatBilling@gmail.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! ~

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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:** ☐ VISA ☐ DISCOVER ☐ MasterCard ☐ AMERICAN EXPRESS

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