

**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/CEO

**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:**

- Inspection of feet, legs and toes
- Toenail trim / file / callus removal
- Massage / moisturize
- Tips and training for care
- 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 **\$50**, payable to **FEET RETREAT, LLC**.

**\$5 discounts are available for:** *prepaid accounts, payments rendered at time of service, and for accounts with an AutoPay 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.**

**X**

\_\_\_\_\_  
*Authorized Signature*

\_\_\_\_\_  
*Date*

Billing Name : \_\_\_\_\_

Billing Address : \_\_\_\_\_

City/State/Zip : \_\_\_\_\_ Phone : \_\_\_\_\_

*If you would like invoices e-mailed to you, please 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. Invoices are sent by mail or can be emailed, if preferred.

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

Use this form to 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 & economical options, please return completed form to us via fax or mail.*

*Thank you!*  
The Billing Dept.  
FEET RETREAT, LLC

**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*

**YES!** Please **e-mail** invoices/paid receipts to: \_\_\_\_\_

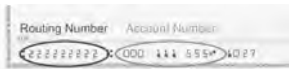
*Please add us to your "trusted" contacts list.*

**OPTION 1 - eCheck (ACH debit):**

Personal Checking

Personal Savings

Business Checking



Bank Routing #: \_\_\_\_\_

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



**Name on Account:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**- OR -**

**OPTION 2 - Credit Card:**



**CARD #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Exp.** \_\_\_\_ / \_\_\_\_

**Cardholder Name:** \_\_\_\_\_

**Billing Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

**CVV CARD SECURITY CODE:** \_\_\_\_\_

*Visa/MC/Disc = last 3 digits on back of card*

*AMEX = 4 digits on card face*