DIAGNOSTIC CENTER

123 Medical Plaza, Health City
Phone: (555) 010-8888
Email: billing@diagnostic.center

REFUND INVOICE

Date: _____
Refund #: _____

PATIENT INFORMATION

Name: _____
Patient ID: _____
Contact: _____

ORIGINAL TRANSACTION

Original Invoice #: _____
Date of Service: _____
Payment Method: _____

Service Description	Original Amount	Refund Reason	Refund Amount
_____	$ _____	_____	$ _____
_____	$ _____	_____	$ _____
		TOTAL REFUND AMOUNT:	**$ _____**

REFUND METHOD

[ ] Credit/Debit Card [ ] Bank Transfer [ ] Check [ ] Original Form of Payment

_____

Authorized Signature

_____

Patient Acknowledgment

Note: Refunds may take 5-10 business days to reflect in your account depending on your financial institution. For billing inquiries, please contact our accounts department.