LABORATORY INVOICE

CLINIC/LAB NAME
123 Lab Lane, Science Park
Contact: (555) 010-9999

Invoice #: _____
Date: _____

PATIENT / CLIENT INFORMATION

Name: _____
ID: _____
Address: _____

ORDER DETAILS

Physician: _____
Specimen ID: _____
Collection Date: _____

Test Code	Description of Analysis	Unit Cost	Total

Subtotal: $ _____
Tax / Handling: $ _____
Amount Due: $ _____

Notes: Results will be released upon full payment. Please reference invoice number on all transfers.

Authorized Signature: _____