PATHOLOGY LAB NAME

123 Medical Plaza, Health City
Phone: (555) 012-3456
Email: lab@example.com

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION:
Name: _____
ID: _____
DOB: _____
REFERRING DOCTOR:
Name: _____
Clinic: _____

Test Code	Description of Service / Test	Unit Price	Total

Subtotal: $_____
Tax/VAT: $_____
GRAND TOTAL: $_____

Payment Terms: Due upon receipt. Please make checks payable to "Pathology Lab Name".

Notes: Clinical laboratory services provided are for diagnostic purposes.