

REFERENCE LAB SERVICES

123 Laboratory Way
Diagnostics City, ST 12345
Phone: (555) 010-9999

INVOICE

Invoice #: _____
Date: _____

BILL TO:

Client/Clinic Name: _____
Address: _____
Account #: _____

PATIENT / REF INFO:

Patient Name: _____
Accession #: _____
Ordering Physician: _____

Test Code	Description of Service / Lab Test	Qty	Unit Price	Total

Subtotal: \$ _____
Tax/Fees: \$ _____

TOTAL DUE: \$ _____

Terms: Net 30 Days. Please make checks payable to "Reference Lab Services".

For billing inquiries, please contact billing@referencelab.example