horizontal line

Laboratory Bill Format

**Laboratory Name  
Laboratory Address  
Contact Information  
Website (if applicable)**

**Bill To:  
Patient Name:** [Patient's Full Name]  
**Patient ID:** [Unique Patient Identifier]  
**Date of Birth:** [DOB]  
**Address:** [Patient's Address]

**Invoice Number:** [Unique Invoice ID]  
**Date:** [Billing Date]  
**Due Date:** [Due Date for Payment, if applicable]

**Description of Services:**

| **Test Performed** | **Description** | **Quantity** | **Unit Cost** | **Total Cost** |
| --- | --- | --- | --- | --- |
| CBC | Complete Blood Count | 1 | $XX.XX | $XX.XX |
| Lipid Profile | Cholesterol Test | 1 | $XX.XX | $XX.XX |
| ... | ... | ... | ... | ... |

**Subtotal:** $[Subtotal Amount]  
**Discount:** $[Discount Given, if any]  
**Tax (X%):** $[Applicable Tax Amount]  
**Total Amount Due:** $[Total Amount Due]

**Payment Method:** [Method of Payment]  
**Payment Status:** [Paid/Unpaid]  
**Payment Date:** [Date of Payment, if already made]

**Notes:**[Additional information, e.g., payment instructions, terms and conditions, etc.]

**Authorized Signature:**[Signature of authorized personnel]

**Thank you for choosing [Laboratory Name].**