Pathology Bill

**Pathology Lab Name  
Lab Address Line 1  
Lab Address Line 2  
Phone Number  
Email Address**

**Receipt Date**: [Date]  
**Receipt Number**: [Unique Receipt Number]  
**Patient Name**: [Patient's Full Name]  
**Patient ID**: [Unique Patient Identifier]  
**Doctor Name**: [Referring Doctor's Name]  
**Date of Service**: [Date of Test]

**Description of Services**:

| **Item Number** | **Description** | **Quantity** | **Unit Cost** | **Total Cost** |
| --- | --- | --- | --- | --- |
| 001 | Complete Blood Count (CBC) | 1 | $50.00 | $50.00 |
| 002 | Lipid Panel | 1 | $45.00 | $45.00 |
| 003 | Thyroid Function Test | 1 | $40.00 | $40.00 |
| 004 | Urinalysis | 1 | $25.00 | $25.00 |
| 005 | Blood Glucose Test | 1 | $15.00 | $15.00 |

**Subtotal**: $175.00  
**Tax (5%)**: $8.75  
**Total Amount Due**: $183.75

**Payment Method**: [Cash/Card/Insurance]  
**Amount Paid**: $183.75  
**Balance Due**: $0.00

**Remarks**:

* Results will be sent to the referring physician.
* Please allow 48 hours for comprehensive panels.

**Lab Technician**: [Technician's Name]  
**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date**: [Date of Issue]

**Thank you for choosing [Pathology Lab Name]. For any queries regarding this bill, please contact us at [Phone Number] or [Email Address].**