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].