HELSE MØRE & ROMSDAL HF
Møre & Romsdal public hospital enterprise

GJELDSERKLÆRING PÅ ENGELSK

(Please print using block letters)

Name: ……...

Date of birth: ……..

Address: ……..

Postal code: …….. **City: ……..**

Country: ……..

Telephone: ……...

Email: ……...

ACKNOWLEDGMENT OF DEBT

I am aware that the debt caused by my stay in Helse Møre & Romsdal HF is my responsibility and will be invoiced to me.

I am also aware that any debt caused by ambulance/taxi transport to and from the hospital is my responsibility.

The invoice issued by Helse Møre & Romsdal HF is to be paid within 30 days from the invoice date. If payment is overdue, the hospital can charge me interest according to Norwegian legislation.

If Helse Møre & Romsdal HF is forced to send the claim to the debt collection, the expenses will be paid by me.

The above acknowledgement is read and understood.

…….. ……
Date the patients signature

Postal address:
Helse Møre & Romsdal HF
Åsehaugen 1
6017 Ålesund
Norway
Phone: + 47 70 10 50 00
Fax: +47 71 21 70 41
E-mail: utland@helse-mr.no

Bank details:
DNB Bank ASA
Dronning Eufemias gate 30
0191 Oslo, Norway
Account No: 1506 90 63338
IBAN: NO43 1506 9063 338
BIC: DNBANOKKXXX
Internet: www.dnb.no