Térítésmentes ellátást biztosító jogviszonnyal elismerten nem rendelkező, magyarul nem beszélő ellátott nyilatkozata térítési díjfizetési kötelezettségéről (angol)

DISCLAIMER

Surname: ……..
First name: ……
Address: ……...
(country, settlement, poste code, number, street)
e-mail address:…….
Date of birth: ……
Place of birth: ……...
Nationality: ……...
Passport number: ……..

I, the undersigned certify that all the data appearing here are valid.

I received healthcare at Semmelweis University from ……. (dd/mm/yyyy) to ……. (dd/mm/yyyy / on ……. (dd/mm/yyyy).

I declare that I do not possess insurance that makes me eligible to receive medical treatment; therefore I am obliged to pay the treatment fee until the **deadline indicated on the receipt**.

I understand that by not being eligible to receive medical treatment, I am obliged to pay the treatment fee **until the deadline indicated on the receipt.**

I understand that failing to pay the fee of the treatment **until the deadline indicated on the receipt** Semmelweis University is entitled to act according to official wind-up procedure.
Fee of health care received is to be transferred to
account: 11784009-22236665-00000000 (OTP Bank)

Date: …….

……
signature

made: 2 copies
1. copies.: Szervezeti egység
2. copies: patient