儿童牙齿福利金计划
汇总结账患者同意书

我，患者/法定监护人，证明我已被告知：

- 根据儿童牙齿福利金计划，已经或者将要自此日期起提供的治疗；
- 此次治疗可能产生的费用；以及
- 根据儿童牙齿福利金计划，我将会接受汇总结账服务，以及我将不会支付这些服务的自付费用，受制于在福利金上限规定下有足够可使用的资金。

我理解我/患者将只会得到最高达到福利金上限的牙齿福利金。

我理解一些服务的福利金可能会有限制，以及儿童牙齿福利金计划覆盖了有限范围的服务。 我理解我需要个人支付不在儿童牙齿福利金计划内的任何服务费用。

我理解服务收费将减少可用的福利金上限，以及我需要个人支付一旦福利金用完后的任何额外服务费用。

_____
患者的国民医疗保健号码

_____
患者/法定监护人签名

_____
患者的全名

_____
签名者的全名
(如果不是患者)

_____
日期

这份同意书有效至签名所属日历年的12月31日。

CHILD DENTAL BENEFITS SCHEDULE
BULK BILLING PATIENT CONSENT FORM

I, the patient / legal guardian, certify that I have been informed:

- of the treatment that has been or will be provided from this date under the Child Dental Benefits Schedule*;*
- of the likely cost of this treatment; and
- that I will be bulk billed for services under the Child Dental Benefits Schedule and I will not pay out-of-pocket costs for these services, subject to sufficient funds being available under the benefit cap.

I understand that I / the patient will only have access to dental benefits of up to the benefit cap.

I understand that benefits for some services may have restrictions and that Child Dental Benefits Schedule covers a limited range of services. I understand I will need to personally meet the costs of any services not covered by the Child Dental Benefits Schedule.

I understand that the cost of services will reduce the available benefit cap and that I will need to personally meet the costs of any additional services once benefits are exhausted.

_____
Patient's Medicare number

_____
Patient / legal guardian signature

_____
Patient's full name

_____
Full name of person signing
(if not the patient)

_____
Date

This form is valid up to 31 December of the calendar year for which it is signed.