兒童牙科福利計劃表
國民醫保卡付費(Bulk Billing)患者同意書

本人，患者/合法監護人，聲明我已被告知以下事項：

- 根據兒童牙科福利計劃表*已經提供或者將從今日起提供的治療；*
- 此治療可能產生的費用；以及
- 根據兒童牙科福利計劃提供的服務將向國民醫保卡收費，如果該服務的收費不超過福利計劃的最高付款額，我將毋須支付額外的款項。

我明白我/患者只會獲得該牙科福利計劃的最高付款額。

我明白某些服務的福利可能有限制，以及兒童牙科福利計劃涵蓋的服務範圍有限。 我明白任何兒童牙科福利計劃未包括的服務，我將要自行付款。

我明白有關服務費用會使用福利計劃提供的款項，因而福利計劃的可用金額會隨之減少，一旦福利計劃的可用金額用完後，我將要自行繳付任何額外服務的費用。

_____
患者的Medicare 號碼

_____
患者/合法監護人簽名

_____
患者全名

_____
簽名人的全名
(如非患者親自簽名)

_____
日期

本同意書有效期到簽署年的12月31日止。

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.