AKUNY KËN-LEC METH GUIR
WƐRƐƆ Ë (BULK BILLING) RAAN TUANY CI YEN GAM

Ɣɛn, anɛn raan tuany / raan atït, gam alɔn adï kë ɣɛn acï lëk:

- ee yelaac cë guïr ka nɔŋ bï yen looi tedɛ̈t abï ya këbï täu tënë akölnïn kënic në löôŋ ë cɔl Akuny Kënë lec Meth Guïr;
- ku jal ya tëcït wëu kadï ë kë tuany kënë luöi yelaac; ku
- eya ɣɛn abï luöi (bulk billed) tëwën yë luɔi thïn në cök dɛn aa Akuny Kën-lec Meth Guir ku ɣɛn abï cïën wëu käk ba tääu-pïny ë jiɛmdï yïc tënë kääŋ bë löi, ye wët tɔu wëu juëc thïn në kuer akuny wën ayök ë juakic.

Ɣɛn acë detic lɔn adï ɣɛn / anɛn raan tuany abï anɔŋ kony kën-lec ayök etök ë tëcït tënë ye akuny wën ya yök ë juakic.

Ɣɛn acë detic lɔn adë konykony tënë kääk ye looi alëu bïk naaŋ thɛny ciën/peen ku Kony kën-lec Meth Guir akë cï juëc akek ë looi. Ɣɛn acë detic ɣɛn abï wëu wïc arot tënë yen aba ya tääu piny ë të ayï kääk wën wïc looi kec maat në Akuny Kën-lec Meth Guïr.

Ɣɛn acë detic lɔn adï ka wëu ë käk looi abï wëu kony dhuk nhïïm pïny ku kënë abï ɣɛn wïc arot ba wëu ë kedääŋ dɛ̈t cï bɛn juak thïn në luɔi tääu-pïny tënë cë wëu kuony ya käk cï thök acïn.

_____
Namba Medicare ë Raan-tuany

_____
Giët ë Raan-tuany / Raan atïït

_____
Rïn ë raan-tuaany ebëne
(Patient's full name)

_____
Rïn raan ë giët wɛrɛŋ yïc ebëne
(Rïn na cië raan tuany yen giet)

_____
Akölnïn

Wɛrɛŋ ë kënë abï gam akölnïn 31 Pɛithïär-ku-rou ë akuën ruön tewen yen ë giët wɛrɛŋ yïc.

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.