儿童牙齿福利金计划
非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，包括任何自付费用；以及
- 这些服务的计费和支付安排

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。

除讨论的自付费用之外，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

根据儿童牙齿福利金计划，这份同意书必须在服务提供当日完成填写。

CHILD DENTAL BENEFITS SCHEDULE
NON-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 on this day under the Child Dental Benefits Schedule;
- the likely cost of this treatment, including any out-of-pocket costs; and
- the billing and payment arrangements for the services.

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 the 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.

In addition to the out-of-pocket costs discussed, 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 must be completed on each day of service provision under the Child Dental Benefits Schedule.