Australian Government

Department of Health, Disability and Ageing

Child Dental Benefits Schedule
Non-Bulk Billing Patient Consent Form

About this Program

The Child Dental Benefits Schedule (CDBS) is an Australian Government program that provides access to basic dental services, within a benefit cap, over a relevant two calendar year period. Services that receive a benefit under the CDBS include examinations, cleaning, x-rays, fissure sealing, fillings, root canals, extractions and partial dentures. The full list of services is available in the Dental Benefits Schedule. The Schedule includes an item number, description, benefit amount and applicable restrictions for each service. Services can be provided in a public or private setting. However, benefits are not available for orthodontics, cosmetic dental or any services provided in a hospital.

A child is eligible for the CDBS if they are:

- 0-17 years old for at least one day that calendar year;
- Eligible for Medicare; and
- Receive a payment from Services Australia at least once a year, or have a parent, carer or guardian who receives a payment from Services Australia at least once a year.

Privacy and Consent information

Your personal information is protected by law, including the *Privacy Act 1988* and the Australian Privacy Principles (APPs), and is being collected by your Dental Provider on behalf of the Department of Health, Disability and Ageing (the department). for the primary purpose of facilitating basic dental services under the Child Dental Benefits Schedule.

If you do not provide this information services will not be able to be provided to you under the CDBS.

By providing your personal information to your Dental Provider you consent to the department collecting this personal information about you from your Dental Provider.

You can access the department's APP privacy policy at https://www.health.gov.au/resources/publications/privacy-policy

The department can be contacted by telephone on (02) 6289 1555 or via email at privacy@health.gov.au

The department will not disclose your personal information to any overseas recipients.

Patient's details

Medicare card number **Ref**

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Given Name

Family Name

Date of Birth

I, the patient/parent/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 and the likely cost of this treatment;
- The billing and payment arrangements for the services;
- That any services that are not covered by the Child Dental Benefits Schedule or exceed the remaining benefit cap amount, may incur an out-of-pocket cost;
- In addition to the out-of-pocket costs discussed, I understand that the cost of services will reduce the available benefit cap and I will need to meet the cost of any additional services once benefits are exhausted; and
- That benefits for some services may have restrictions, and that the Child Dental Benefits Schedule covers a limited range of dental services.

NB: This form must be completed on each day of service provision under the Child Dental Benefits Schedule.

Full name (print in BLOCK LETTERS)

Signature

Date

Patient ☐ Parent ☐ Legal Guardian ☐
(tick one only)

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