



AKUNY KĒN-LEC METH GUIR WĒRĒŋ Ē (BULK BILLING) RAAN TUANY CI YEN GAM

Yen, anen raan tuany / raan atit, gam alon adi kē yen aci lēk:

- ee yelaac cē guir ka nōŋ bi yen looi tedēt abī ya kēbi tāu tēnē akōlnīn kēnic nē lōōŋ ē cōl Akuny Kēnē lec Meth Guir;
- ku jal ya tēcīt wēu kadī ē kē tuany kēnē luōi yelaac; ku
- eya yen abī luōi (bulk billed) tēwēn yē luoi thīn nē cōk den aa Akuny Kēn-lec Meth Guir ku yen abī ciēn wēu kāk ba tāau-pīny ē jiēmdī yīc tēnē kāāŋ bē lōi, ye wēt tōu wēu juēc thīn nē kuer akuny wēn ayōk ē juakic.

Yen acē detic lōn adi yen / anen raan tuany abī anōŋ kony kēn-lec ayōk etōk ē tēcīt tēnē ye akuny wēn ya yōk ē juakic.

Yen acē detic lōn adē konykony tēnē kāk ye looi alēu bīk naaŋ theny ciēn/peen ku Kony kēn-lec Meth Guir akē cī juēc akek ē looi. Yen acē detic yen abī wēu wīc arot tēnē yen aba ya tāau pīny ē tē ayī kāk wēn wīc looi kec maat nē Akuny Kēn-lec Meth Guir.

Yen acē detic lōn adi ka wēu ē kāk looi abī wēu kony dhuk nhīim pīny ku kēnē abī yen wīc arot ba wēu ē kedāāŋ dēt cī ben juak thīn nē luoi tāau-pīny tēnē cē wēu kuony ya kāk cī thōk acīn.

Namba Medicare ē Raan-tuany

Giēt ē Raan-tuany / Raan atit

Rin ē raan-tuaany ebēne
(Patient's full name)

Rin raan ē giēt wēreŋ yīc ebēne
(Rin na ciē raan tuany yen giet)

Akōlnīn

Wēreŋ ē kēnē abī gam akōlnīn 31 Peithiār-ku-rou ē akuēn ruōn tewen yen ē giēt wēreŋ yīc.



**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.