



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.