AKUNY KËN-LEC METH GUIR

WƐRƐŊ Ë (NON-BULK BILLING) RAAN TUANY YË GAM

Ɣɛn, anɛn raan tuany / raan atït , gam lɔn na dï kɛ̈ ɣɛn acï lëk ee:

* ka dë yelaac cë guïr alëk kawïc ulä abï täu tënë akölnïn kënic ye kuer ë lööŋ cɔl akuny Kën-lec Meth Guïr*;*
* aa tëcit wëu ë ke yelaac kënë looi, amaat thïn agut yï lɔn cï wëu ɣe jiɛm yïc thök; ku
* jal atuc ë wɛrɛŋ ye wëu tääu-pïny ë cɔl billing ku tëdɛ̈t ka guïr tääu wëu piny tëden këwen cï luoi.

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

***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.***

***Këdɛ̈t cï maat thïn tënë luɔi yë looi tëci wëu thök në jiɛmïc cï jam yic kënë, ɣɛn acë detic lɔn adï ka wëu ë kääŋ looi ebɛ̈ne abï wëu kony dhuk nhïïm piny ku kënë abï ɣɛn wïc arot ba wëu ë kedääŋ dɛ̈t cï bɛn looi thïïn ya tääu-pïny tëcï wëu kony ya käk cï thök acïn*.**

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Namba Medicare ë Raan-tuany Giët ë Raan-tuany / Raan atïït

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Rïn ë raan-tuaany ebëne Rïn raan ë giët wɛrɛŋ yïc ebëne
(Patient’s full name) (Rïn na cië raan tuany yen giet)

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Akölnïn

Wɛrɛŋ kënë abë dhïl ya athiöŋ yïc aköl tökic tëden luɔi cï looi ë kuer Kuony Kën-lec Meth Guïr.

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*.**

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Patient’s Medicare number Patient / legal guardian signature

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Patient’s full name Full name of person signing
(if not the patient)

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Date

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