



AKUNY KĒN-LEC METH GUIR
WEREŊ Ě (NON-BULK BILLING) RAAN TUANY YĚ GAM

Yen, anen raan tuany / raan atit, gam lon na di kē yen aci lēk ee:

- ka dē yelaac cē guir alēk kawic ulā abi tāu tēnē akōlnin kēnic ye kuer ē lōōŋ cōl akuny Kēn-lec Meth Guir;
- aa tēcit wēu ē ke yelaac kēnē looi, amaas thīn agut yī lon cī wēu ye jiem yic thōk; ku
- jal atuc ē wereŋ ye wēu tāau-pīny ē cōl billing ku tēdēt ka guir tāau wēu piny tēden kēwen cī luoi.

Yen acē detic lon nadī yen/ anen raan tuany abi anōŋ kony kēn-lec ayōk etōk ē tēcit tēnē ye akuny wēn ya yōk ē juakic.

Yen acē detic lon adē konykony tēnē kāāk ye looi alēu bik naaŋ theny ciēn/peen ku Kony kēn-lec Meth Guir akē cī juēc akek ē looi. Yen acē detic yen abi wēu wic arot tēnē yen aba ya tāau piny ē tē ayī kāāk wēn wic looi kec maat nē Akuny Kēn-lec Meth Guir.

Kēdēt cī maat thīn tēnē luoi yē looi tēci wēu thōk nē jiemic cī jam yic kēnē, yen acē detic lon adī ka wēu ē kāāŋ looi ebēne abi wēu kony dhuk nhūm piny ku kēnē abi yen wic arot ba wēu ē kedāāŋ dēt cī ben looi thīn ya tāau-pīny tēci wēu kony ya kāk cī thōk acin.

Namba Medicare ē Raan-tuany

Giēt ē Raan-tuany / Raan atit

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

Rin raan ē giēt wereŋ yic ebēne
(Rin na ciē raan tuany yen giet)

Akōlnin

Wereŋ kēnē abē dhil ya athiōŋ yic akōl tōkic tēden luoi cī looi ē kuer Kuony Kēn-lec Meth Guir.



**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.