兒童牙科福利計劃表
非國民醫保卡付費(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：

- 今天本人/患者已經得到或將會得到根據兒童牙科福利計劃*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，包括任何我需要自行付款的費用；以及
- 此服務的收費安排。

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。

除了之前提及的需要我自行付款的費用以外，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

每次兒童牙科福利計劃向我提供服務，我都必須完成本同意書。

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.