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 tëdët 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.

Këdët 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 ebëne abï wëu kony dhuk nhïïm piny ku kënë abï ɣɛn wïc arot ba wëu ë kedääŋ dët cï bɛn looi thïïn ya tääu-pïny tëcï wëu kony ya käk cï thök acïn.

_____
Namba Medicare ë Raan-tuany

_____
Giët ë Raan-tuany / Raan atïït

_____
Rïn ë raan-tuaany ebëne
(Patient's full name)

_____
Rïn raan ë giët wɛrɛŋ yïc ebëne
(Rïn na cië raan tuany yen giet)

_____
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.

_____
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.