Australian Government
Department of Health

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.