Tatura Dental Care

Health Directed Dentistry
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CHILD DENTAL BENEFITS SCHEDULE - PATIENT CONSENT FORM

I, the patient / legal guardian, certify that I have been informed of:

- of the treatment that has been or will be provided from this date 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.
- that I will be bulk billed for services under the Child Dental Benefits Schedule and I will not pay out-of-pocket costs for these services, subject to sufficient funds being available under the benefit cap.

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: Exp Date:
Ref No: Patient's full name:

By ticking this box I agree to the above information, terms & conditions. ☐

Patient / legal guardian Full Name:

This form is valid up to 31 December of the calendar year for which it is signed.