Queensland Government

CHILD DENTAL BENEFITS SCHEDULE
BULK BILLING PATIENT CONSENT FORM

(for services provided in a Queensland Health public sector dental clinic)

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

- of the treatment that has been or will be provided from this date under the Child Dental Benefits Schedule;
- of the likely cost of this treatment; and
- 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. Once my benefit cap has been reached I will not need to pay any out-of-pocket costs provided I am eligible for services in a Queensland public dental health clinic.

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 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 or Queensland Public Dental Services.

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 not covered by Queensland Public Dental 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 is valid up to 31 December of the calendar year for which it is signed.