SERVICE DISCLOSURE STATEMENT

BULK BILLING INFORMATION

The Medicare Benefit amounts for each service we may provide are below. These are set by the Department of Health and not School Dental. Any combination of these will make up the total amount that will be claimed for the respective service rendered to your child:

ITEM	SERVICE	BENEFIT
88011	Comprehensive Oral Examination	$52.65
88012	Periodic oral examination	$43.75
88013	Limited Oral Examination	$27.50
88111	Removal of Plaque / Stain	$53.80
88114	Removal of Calculus – 1st visit	$89.70
88121	Topical Remineralisation agents	$34.55
88022	Periapical or Bitewing X-ray	$30.45
88161	Fissure Sealants	$46.05
88162	Fissure Sealants - Subsequent Services	$23.05

The most common treatment combinations (for claim totals, refer above):

- 88011, 88111, 88121, 88022 (x2), 88161 (x4)
- 88011, 88111 or 88114, 88121, 88161 (x4)
- 88011, 88121 with or without 88022 (x2)
- 88011, 88022 (x2)
- 88013

Please note the practitioner may require taking more x-rays to form a complete treatment plan.

Your child must be eligible for the Child Dental Benefits Schedule to be able to make claims under it. You can find more information about the Child Dental Benefits Schedule and how it works at:
www.humanservices.gov.au/childdental

SCHOOL DENTAL does not set the standard terms and prices of the Medicare CDBS, these are set by the Department of Human Services. SCHOOL DENTAL does not undertake to provide any advice as to the requirements of the Medicare CDBS and you should read the information detailed at: www.humanservices.gov.au/childdental

PRIVATE PAYMENT OPTION

We appreciate that not all students will be eligible for the Medicare Child Dental Benefit Schedule. Our billing prices are LOWER than Medicare.

For your child's 1st visit, we will conduct a:
Check-up and Clean for $65.00

If you have private health insurance, you may be able to reclaim a percentage of this price from your insurer. Once we have completed this treatment for your child, we will send out and invoice to you. This can be used for claiming back from your insurance.

If you would like for your child to be seen by us, please fill out the payment details and send this form back to school.

I, _____
give consent for my child
_____

to undertake a Check Up and Clean by School Dental for a total cost of $65.00. I understand and give consent for payment to be taken from my card details below if I have chosen to pay by card.

Signature: _____ Date: / /

CASH PAYMENT:
If you wish to pay by cash, please place the exact amount shown above in an envelope with this form completed.

CARD PAYMENT:
I authorise and request School Dental (ABN 70 167 901 751), to arrange for the above amounts, which become payable in relation to the oral health services provided to my child to be debited through the credit card listed below. This authority will stand in respect of the specified card and in respect of any card issued to me in renewal or replacement, until I notify School Dental of its cancellation.

Card Holder's Name: Expiry

Card type: ☐ VISA ☐ Mastercard

Card Number: CCV

Card Holder's Signature:

SCHOOL DENTAL
It all starts with the kids

9/62a Albert Street
Preston, VIC. 3072
Ph (03) **9972 8713**
info@schooldental.com.au
www.schooldental.com.au

PLEASE FILL ALL HIGHLIGHTED SETIONS

Dear Parent/Guardian,

School Dental is pleased to inform you that we will be providing dental treatment for students at your child's school. **We will be conducting the Dental Visits in the coming weeks.** We make your child's dental visits more convenient for you, by seeing them during school hours. This will prevent them being absent from school for their dental visits and allowing them to make the most out of their school day. We will be conducting the Dental Visits in two separate Phases.

Phase 1: Detect, Arrest and Prevent!
During this phase, we will conduct Preventative Dental Visits. This may include an Examination, Clean, Preventative Bitewing X-rays, Remineralisation Agent Application and Preventative Fissure Sealants on teeth. Fissure Sealants are a coating placed on teeth without any drilling, to protect against decay. Any reports or Treatment Plans will be sent via email to you outlining any further treatment your child may need.

Phase 2: Rehabilitate and Protect!
The Phase 2 visit is usually held 3 – 8 weeks after the first visit. During this visit we will complete any relevant treatment your child may need. We highly recommend parents to attend these appointments during our Phase 2 visit. Parents will be informed of the times of their child's appointments beforehand.

This treatment may be covered by the Medicare Child Dental Benefits Schedule (CDBS) for eligible children. To find out if your child is eligible under the CDBS please give Medicare a call on 132 011.

School Dental will also check eligibility of students and inform parents who are unsure of their child's eligibility. For children who may not be eligible for the Medicare CDBS, School Dental is able to see students as private patients. You will be billed at a rate LOWER than that of Medicare. The treatment may be claimable under your private health insurance. Please refer to the Service Disclosure Statement on the back of this form for more information.

For your child to be seen by School Dental, please fill in the attached forms and return it to your school as soon as possible. Only children who have had this form filled in can be processed and seen by School Dental.

If you would like any further information or hold any queries feel free to contact us on (03) 9972 8713. We look forward to seeing your child!

School Dental Team.

All School Dental forms are protected by Copyright laws.

MEDICAL HISTORY & CONSENT

- I give consent for School Dental to provide dental treatment to my child, which MAY include, but not limited to, a Dental Examination, Dental Clean, Bite-wing X-rays and a Topical Remineralisation application. I understand the nature of and give consent for Fissure Sealants to be placed on any required teeth for my child including Baby and Adult Molars.

- I give consent for my child's dental condition information to be collected anonymously for research. I acknowledge that I have read and understood the Service Disclosure Statement. I also understand that my child's information is private and confidential and will be stored securely by School Dental. School Dental staff members involved in my child's care can only access it. My child's information will only be released if I agree or if required by law. I understand that School Dental may contact me regarding my child's oral health, appointments or accounts. I confirm and acknowledge that the information provided is accurate and true to the best of my knowledge.

Child's Full Name: _____ **D.O.B:** _____ **Male / Female**

School Name: _____ **Year Level / Class:** _____

Residential Address: _____ **Postcode:** _____

Parent/Guardian Name: _____ **Phone:** _____

Email: _____

If your child is not eligible for the Medicare CDBS, would you like to be contacted regards private payment options?
YES / **NO** (Please Circle)

DOES YOUR CHILD HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?
Please tick 'Yes' or 'No' for each condition.

	Yes	No		Yes	No
Heart disorder / complaint			Hep. A, B or C (Please circle)		
Rheumatic fever/heart murmur			Anaemia or other blood disorders		
Cardiac Pacemaker			Excessive bleeding		
High or low blood pressure			Contact with HIV or AIDS		
Fainting/dizziness			Thyroid disease		
Stroke			Bone or joint replacement, including		
Asthma			osteoporosis		
Bronchitis, Emphysema, TB or other			Prosthetic implant e.g. Hips, knee		
lung disease			Cancer		
Diabetes: type 1 or 2 (Please circle)			Radiation therapy		
Epilepsy			Steroid therapy		
Kidney Disease			Stomach or digestive problem		
Liver Disease			Nervous condition		
Any other conditions not listed above (please list):					
Any current medications (please list):					
Any allergies (please list):					

Parent/Guardian Signature: _____ Date: _____

Australian Government
Department of Health

CHILD DENTAL BENEFITS SCHEDULE
BULK BILLING PATIENT CONSENT FORM

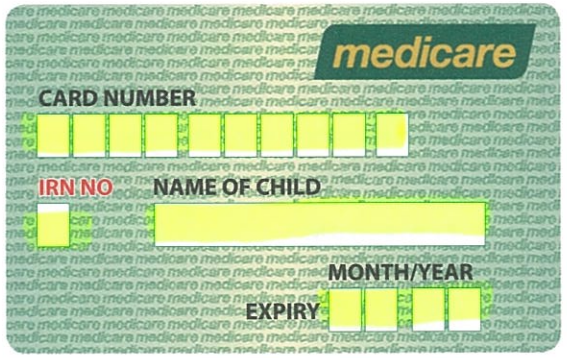
I, the patient / legal guardian, certify that I have been informed:

- Of the treatment that has been or will be provided 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.

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.

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.



_____
Full Name of person signing (if not the patient)

_____
Patient / Legal Guardian Signature

PLEASE SIGN HERE

____ / ____ / ____
Date

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