HEALTH SERVICE - NOTICE OF WITHDRAWAL FROM A CAPITATION OR CONTINUING CARE ARRANGEMENT

Dentist's name Address: Contract No.	Patient's name _____ First name _____ DOB/CHI No. _____ Address:

I intend to withdrawn from the arrangements with the above patient.

Dentist's signature _____ Date _____

PLEASE TICK ALL RELEVANT BOXES

1. ☐ I intend to withdraw from the arrangement with the above patient 3 months from today

2. ☐ I wish to withdraw at once because the patient owes me £ _____ in respect of _____.
I have taken the following action to obtain payment
_____
_____

3. ☐ I wish to withdraw, with effect from _____. The patient/patient's parent/guardian and I have agreed that all care and treatment is to be provided privately.

I agree that my / _____ care and treatment is to be provided privately by the dentist named above from _____.

I understand that I will have to pay for all care and treatment provided for me.

I also understand that DHSS cannot help me with the cost of this care and treatment even if my income is low.

Signature _____ Date _____

4. ☐ I wish to withdraw at once/from _____
because _____.

5. ☐ There will be no treatment outstanding when the arrangement ends.

☐ The following care and treatment will be outstanding when the arrangement ends: _____

☐ I have made the following arrangements for outstanding treatment to be completed: _____