Complaint/Grievance Form

Patient Information

Patient Name: _____

Local Address: _____

Telephone Number: _____ Date of Birth: _____

Best day/time to be reached: _____

Complainant Information

Name of Person Initiating Complaint: _____

Address: _____

Telephone Number: _____ Relationship to Patient: _____

Nature of Complaint

_____ Appointment/Access _____ Physical Exam _____ Problem w/staff _____Policies

____Medication Refills _____ Billing ____ Lab Results ____Referrals ____Problem with MD,

Other_____

Time & Date of Incident:

_____

Names of Staff Involved (If known):

_____

In your own words please tells us why you are not happy with the care or service you received:

_____

_____

_____

_____

_____

As a result of your complaint, what would you like to see happen?

_____

_____

_____

_____

I understand that staff investigating this complaint may need to see and review health records, but that all information will be kept confidential. I further understand that this complaint/grievance will in no way affect any care provided.

Signature: _____ Date: _____