

COMPLAINANT/REPORTER

Your Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____ *City* *State* *ZIP Code*
Home Telephone: () Work Telephone: () **Best Time to Call:**

PATIENT INFORMATION (Complete this section if Patient is not the same as Complainant/Reporter)

Name of Patient: _____
Last *First* *M.I.*

Date of Birth ____/____/____ Social Security Number ____ - ____ - ____

Address: _____
Street Address *Apartment/Unit #*

_____ *City* *State* *ZIP Code*
Home Telephone: () Work Telephone: ()

YOUR RELATIONSHIP TO PATIENT

- Self Parent Son/Daughter Spouse Brother/Sister Friend Other Medical Practitioner
- *** Legal Guardian/provide court documents Other _____

NATURE OF COMPLAINT/REPORT (Please check all that apply.)

- Quality of Care Quality of Product Billing issue
- Conduct of Personnel Prescription not filled correctly Injury due to medical device
- Insurance Fraud Failure to release patient records Sexual Harassment
- HIPPA Violation Problem other than listed above _____

Have you attempted to contact the practitioner concerning your complaint? Yes (Date: _____) No

Please give full details of your complaint/report: include facts, details, dates, locations, etc. Please attach copies of medical records, correspondence, contracts, and any other documents that will help support your complaint. (Attach additional sheets if necessary).

I have attached copies of medical records, correspondence, contracts, and any other documents that will help support my complaint.

WHAT WOULD SATISFY YOUR COMPLAINT?

Signature _____ Date _____