Grievance Form

Complainant Information:

Name of person filing complaint: _____

Phone Number: _____ Email: _____

Best time to contact you by phone: _____

Client Name: _____ Relationship to client: ___ Self ____ Parent/Guardian

Time and Date of Incident: _____

Name of provider or support staff member involved: _____

In your own words, please identify your complaint or concern: ___ Scheduling ___ Billing ___ Other:

_____
_____
_____
_____
_____

As a result of your complaint, what would you like to see happen to resolve the issue:

____ Transfer to another provider in group ____ Referral to provider outside of group practice

____ Other (please specify):

_____
_____
_____

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

_____ _____

Signature *Date*