



PATIENT GRIEVANCE FORM

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____ Cell: _____

Submitted by: _____

Medical record # _____

This concern is regarding a referral or PRC: Yes No

This concern is regarding my patient care: Yes No

This concern is regarding a HIPAA or Privacy Act violation: Yes No

1. Did you discuss this concern with a member of your health care team? Yes No

2. Please write a brief statement regarding the following:

Who was involved: _____ When did the issue occur: _____

Where did the issue occur: _____

What happened? *(Use back of form if necessary and/or attach related documents)*

(Optional) I feel this concern could be resolved by: _____

I authorize the White Cloud Health Center Compliance Officer and Committee members to review the above concern in my behalf.

Signature

Date

Return to: White Cloud Health Center Compliance Officer
3349B Thrasher Road, White Cloud KS 66094
chasity.davis@ihs.gov or 785-595-3457

PATIENT GRIEVANCE INFORMATION

Our Code of conduct outlines the standard that we shall provide exemplary care to patients, demonstrate respect and dignity toward all members of the White Cloud Health Center community, honor patients' right to privacy, comply with all applicable laws, avoid conflicts of interest, and conduct all business practices with honesty and integrity by adhering to the following tenants:

- Providing quality care and protecting patient rights;
- Complying with all applicable laws, regulations and promoting ethical conduct;
- Avoiding conflicts of interest and making decisions that are in the best interest of White Cloud Health Center and the patients served;
- Promoting a safe environment for staff, physicians, employees and patients; and
- Do not portray the White Cloud Health Center or the Iowa Tribe of Kansas and Nebraska in a negative or demeaning nature to patients, co-workers, or general public.

If your patient experience did not meet these expectations, you have the right to report a complaint/grievance about your health service experience. Understanding the patient experience is vital for the WCHC to ensure we are providing quality care to our patients.

Health Center Staff shall try to settle any patient problem at the time it takes place. If that is not possible, patients are encouraged to submit a written grievance. The Compliance Officer will ensure the grievance is appropriately reviewed and investigated.

To submit a written complaint, do the following:

1. Submit your grievance in person or mail to:

Compliance Officer
White Cloud Health Center
3349B Thrasher Road
White Cloud, KS 66094

If you need help writing the complaint, our employees will be happy to assist you.

2. You can use this Patient Grievance form as your written complaint. It is available in patient care areas and online at www.whitecloudhealthcenter.org.
3. Non-anonymous grievances will receive a written response to their concern, typically within 60 days.
4. If a patient does not feel the matter has been appropriately resolved, they may contact the Clinic Director.
5. **Filing a complaint will not interfere with access to services or quality of services.**