2921 Lackland Rd. Suite 101
Fort Worth, TX 76116
Phone: 210-216-6367
Fax: 469-532-0204

PATIENT COMPLAINT/GRIEVANCE FORM

Patient Information:

Patient Name: _____

Address:_____

Phone Number:_____ Date of Birth:_____

Complainant Information:

Name of person filling out form if other than patient:

Mailing Address:

Phone Number: _____ Relationship to Patient: _____

Time & Date of Incident: _____Name of Staff Involved (if known):_____

In your own words, please tell 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 _____

Thank you for taking the time to bring your complaint to our attention. You should receive a response within 30 days.

---------- **Office Use Only** ----------

Date complaint received: _____Received by: _____

Reviewed by: _____
Notes: