***Counselling***

**Client Feedback and Complaint Form**

Date:

**Client Details**

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| --- | --- |
| Client Name: |  |
| Address |  |
| Phone Number: |  |
| Email Address: |  |

**Feedback/Complaint Details:**

1. Please describe the nature of your feedback or complaint:

2. Which aspect(s) of the service are you providing feedback or making a complaint about? (Please tick all that apply):

|  |  |
| --- | --- |
| Therapist's conduct |  |
| Quality of care |  |
| Communication issues |  |
| Appointment scheduling |  |
| Billing or payment issues |  |
| Confidentiality concerns |  |
| Facility cleanliness or safety |  |
| Other |  |

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| --- |
| Other (please specify): |
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3. When did this issue occur? (Please provide a date or timeframe):

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4. Have you discussed this issue with anyone at the practice? If yes, please provide details:

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5. What outcome or resolution are you seeking?

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Thank you for taking the time to provide us with your feedback. We take all feedback and complaints seriously and are committed to addressing any issues promptly and effectively. We will review your feedback and get back to you as soon as possible. If you have any immediate concerns or require further assistance, please do not hesitate to contact us at 0413932941 or email admin@indysupportservices.com.au

Client Signature:

Date:

**For Practice Use Only:**

- Received By:

- Date Received:

- Action Taken: