

PATIENT GRIEVANCE FORM

All patient grievances are confidential. This report and any attachments are part of **Surgical Center of the Treasure Coast** Grievance Policy and therefore protected confidential documents under the law. All grievances will be given serious attention.

This patient grievance form will be forwarded to the center leaders to address your concerns.

PERSON REGISTERING THE GRIEVANCE

Name: _____
Last First MI

Mailing Address: _____

City State Zip

Patient Name: _____
Last First MI

Contact Phone Number: _____

Patient Date of Birth: _____ **Your Relationship to Patient:** _____

NATURE OF GRIEVANCE

Date of Service: _____ **Account number:** _____

Facility Name: _____

Please check the box that best describes the nature of your complaint/concern and provide details below:

- Balance Due
- Billed Charges/Services
- Adjustments
- Payments
- Refund Due
- Other _____

Describe problem or reason for complaint: _____

