

## PATIENT GRIEVANCE FORM

All patient grievances are confidential. This report and any attachments are part of **Emerald Coast Surgery Center** 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:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

