Cleveland Clinic

Grove Place Surgery Center

Patient Grievance Form

All patient grievances are confidential. This report and any attachments are part of **Grove Place 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: ____

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____

____

Patient/Guardian/Representative Signature: ____________________________ Date: _______________

Email Address Required to Receive Acknowledgement:

____

Please Mail to: Grove Place Surgery Center
April Thompson, Administrator
1325 36th Street, Suite B
Vero Beach, FL 32960

************ **FOR OFFICE USE ONLY** ************

Date Received: ____________________________

Routed to: ☐ Business Office Manager/CEO ☐ Central Billing Office (if applicable)

Acknowledgement sent by: ☐ Email ☐ Letter Date Sent:

CEO/BOM Signature: ____ *Date:* _______________