

All patient grievances are confidential. This report and any attachments are part of **Stuart 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:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Balance Due | <input type="checkbox"/> Payments |
| <input type="checkbox"/> Billed Charges/Services | <input type="checkbox"/> Refund Due |
| <input type="checkbox"/> Adjustments | <input type="checkbox"/> Other _____ |

Describe problem or reason for complaint: _____
