Patient Complaint Form

Name of Patient	Patient Phone Number:	Date of Event	Date Complaint Filed
Patient Address:	Name of Individual Filing Complaint:	Health Insurance Company:	

Complaint filed by:

☐ Patient ☐ Caregiver ☐ Responsible Party/POA ☐ Healthcare Professional ☐ Other:_____

May we contact you regarding your concerns? ☐Yes ☐No

Type of Complaint

☐Customer Service/Training ☐Delivery of Service ☐Billing ☐Continuity of Care ☐HIPAA Privacy/Security ☐Other:_____

Description of Complaint:

Phone Number:	Print Name:
Email Address:	Signature:

Effective Date: August 30, 2016

Mail to: 5169 Brunswick Rd Box 305 Brunswick, TN 38014 or Fax to: 901-388-0407