PATIENT COMPLAINT FORM

Please let us know if you have a complaint or concern about the service you have received from any of our personnel.

HOW TO COMPLAIN

We aim to resolve most problems quickly and easily, often at the time they arise and with the person concerned. If you wish to make a formal complaint, please do so as soon as possible—ideally within a few days—so we can more easily establish what happened. If that is not possible, please submit your complaint within one month of the incident. Please be as specific and concise as possible.

COMPLAINING ON BEHALF OF SOMEONE ELSE

We strictly adhere to the rules of medical confidentiality. If you are complaining on behalf of a patient, you must have their permission to do so. Unless they cannot provide this due to illness or infirmity, we will need a signed authorization from the patient. A Third-Party Consent Form is provided below.

WHAT WE WILL DO

We will initiate an investigation within 24 hours of becoming aware of any incident resulting in a patient's hospitalization or death. We will acknowledge your complaint within three working days and aim to resolve it within 14 days. If we expect it to take longer, we will explain the reason for the delay and tell you when we expect to finish. When we look into your complaint, we will investigate the circumstances, make it possible for you to discuss the problem with those concerned, and take steps to ensure any problem does not arise again.

TAKING IT FURTHER

If you remain dissatisfied with the outcome, you may refer the matter to MEDICARE at 1-800-MEDICARE.

You will receive communication about the results of any practice investigations.

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COMPLAINT FORM

Patient Full Name:

Date of Birth: **Address:**

Complaint details: (Include dates, times, and names of practice personnel, if known)

SIGNED……. Print name…… (Continue overleaf if necessary)

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139 Weston Oaks Ct. | Cary, NC 27513

PATIENT THIRD-PARTY CONSENT

PATIENT'S NAME: _____
TELEPHONE NUMBER: _____
ADDRESS: _____
_____

COMPLAINANT NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____
_____

IF YOU ARE COMPLAINING ON BEHALF OF A PATIENT OR YOUR COMPLAINT OR ENQUIRY INVOLVES THE MEDICAL CARE OF A PATIENT, THEN THE CONSENT OF THE PATIENT WILL BE REQUIRED. PLEASE OBTAIN THE PATIENT'S SIGNED CONSENT BELOW.

I fully consent to All American Medical Supply releasing information concerning this complaint and discussing my care and medical records with the person named above. I wish this person to complain on my behalf.

This authority is for an indefinite period / a limited period only (delete as appropriate)

Where a limited period applies, this authority is valid until..... (insert date)

Signed: ..... (Patient only)

Date: .....

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