BROAD TOP AREA MEDICAL CENTER, INC.
Patient Grievance / Complaint Form

Patient Information:

Patient Name: _____

Address: _____

Telephone #: _____ Date of Birth: _____

Complaint Information:

Name of Person Initiating Complaint: _____

Address: _____

Telephone #: _____ Relationship to Patient: _____

Nature of Complaint:

☐ Appointment/Access	☐ Problem with Staff	☐ Policy/Procedure
☐ Billing	☐ Laboratory	☐ X-Ray
☐ Problem with Provider	☐ Referral	☐ Medical Care

☐ Other: _____

Time & Date of Incident: _____

Names of Staff Involved (if known) or Practice Location: _____

In your own words, please tell us why you are not happy with the care or service you received:

_____

_____

_____

_____

(Please continue on a separate sheet, if necessary.)

As a result of your complaint, what would you like to see happen?

_____

I understand that staff investigating this complaint may need to see and review health records, but all information will be kept confidential. I further, understand that his grievance/complaint will in ono way affect any care provided.

Signature: _____ **Date:** _____

Thank You, for taking time to bring your complaint to our attention. You should receive a response within 30 days.
Please, return this form to:
Broad Top Area Medical Center, Inc. 4133 Medical Center Drive, Broad Top, PA, 16621-9001 or via FAX: 814-635-7354