

PATIENT GRIEVANCE FORM

All patient grievances are confidential. This report and any attachments are part of **Mohawk 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 Stat Zi

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: _____

Patient/Guardian/Representative Signature: _____ Date: _____

Email address Required to receive acknowledgement: _____

Please Mail to:
Mohawk Surgery Center
Brooke Nezda, CEO
201 Mohawk Road, Ste 200
Minneola, FL 34715

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

Date Received: _____

Routed to:

Business Office Manager/CEO

Central Billing Office (if applicable)

Bu

Acknowledgement sent by: Email Letter

_____ Date Sent:

CEO/BOM Signature: _____ Date: _____
