For Office Use Only
In Office Use Area
Resolution Date _____
Initial Response _____
Patient Satisfaction Rating ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Medical Clinic 605-367-8793
FAX 605-367-8247

Dental Clinic 605-367-8022
FAX 605-367-8001

Nurse
FAX 605-367-8211

City of Sioux Falls
TTY/Hearing Impaired 605-367-7039

FALLS COMMUNITY health

521 North Main Avenue
Sioux Falls, SD 57104
www.siouxfalls.org

Patient Inquiry/Concern

Date of Contact: _____

Inquiring/Concerned Party: _____ Relation to Patient: _____

Patient Name: _____ Patient No.: _____
(if different than person filing the concern.)

Patient's Address: _____

Phone No.: _____

Type of Concerns:

- ☐ Access to appointment availability
- ☐ Access to timely clinical advice
- ☐ Billing
- ☐ Privacy
- ☐ Quality of care (outcome of care, explanation of care)
- ☐ Quality of service (time waiting in office, manner of staff, timely notification of tests)
- ☐ Other

Description of Inquiry/Concern:

Desired Response: ☐ None ☐ Phone Call ☐ Letter ☐ Email: _____

Signature: _____

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Outcome (How the issue was resolved?): _____

_____

_____

_____

_____

Signature: