PATIENT INQUIRY CONCERN FORM

FALLS COMMUNITY health

Date of Contact: _____

Concerned Party: _____

Relation to Patient: _____

FOR OFFICE USE ONLY - IN OFFICE USE AREA
Resolution Date _____
Initial Response _____
Patient Satisfaction Rating: ☐5 ☐4 ☐3 ☐2 ☐1

(If different than person filing the concern)

Patient Name: _____ _____ _____
Last First MI

Patient's Address: _____ Patient ID Number: _____

Phone Number: _____ Work Number: _____

TYPE OF CONCERNS:

- ☐ Quality of care (outcome of care, explanation of care)
- ☐ Quality of service (time waiting in office, manner of staff, timely notification of tests)
- ☐ Billing
- ☐ Privacy
- ☐ Other

Description of Concern:

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

Signature: _____

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Outcome (How issue was resolved)

Signature: _____