EYE SURGERY CENTER AT THE BILTMORE
PATIENT GRIEVANCE FORM

If you are requesting assistance in resolving a problem with this organization, please fill out the sections that relate to your concern(s). Return the form to the receptionist or to the following address:

Attention to the Administrator
2222 East Highland , Suite 101
Phoenix, Arizona, 85016

Optional Information:

Patient Name: _____

Address: _____

City: _____ State: _____

Daytime Phone: _____

May we leave a message for you on the telephone answering machine? ☐ yes ☐ no

Grievance Involves: (check the one that applies)

☐ Organizational staff

☐ Treatment Related/Quality of Care

☐ Other (specify)

☐ I choose to remain anonymous. I understand by remaining anonymous this may result the inability to fully process my grievance.

☐ I choose to represent myself during this grievance process.

☐ I have chosen a representative to help me during this grievance process.
Please list the name and relationship if any of the representative:

_____

_____ _____

Signature of Patient/Person Filing Grievance Date

Signature of Patient/Person Filing Grievance _____ Date _____

Describe your grievance in detail:
List dates and approximate times when incident or action occurred. Please remember to restrict your comments to the facts associated with this grievance. Attach additional sheets if necessary.

Office Use below this line:

Date Received: _____

Date Reviewed by: _____ *Title:* _____

Reported to the Medical Director on: _____

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