PATIENT COMPLAINT FORM

6250 Shiloh Road
Alpharetta, GA 30005
NeuroMatrix.com

800-393-6118

Fax: 866-879-5370

_____/_____/_____
Date

_____
Print Name of Patient with Complaint

_____
Chart #

_____(_____)_____-_____
Patient's Address & Telephone #

Please describe the complaint and include any pertinent information (names, titles, etc.):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient's Signature: _____Date: _____/_____/_____
(If this form was written on behalf of the patient, please check here: □) (If this complaint was taken via phone, please check here: □)

Reporter's Signature: _____Date: _____/_____/_____

Reporter's Printed Name_____Relationship to Patient _____

All complaints (anonymous or signed) will be given serious attention. No one should not fear reprisal because of their complaints.

Form will be delivered to NeuroMatrix® Privacy Officer who will address your concerns.