PATIENT Urgent Care Clinic

Grievance Form

Patient Information

Name (Last, First, Middle Initial)

Mailing Address (Street, City, State, Zip)

Telephone Number

Provider Information

Doctor/Provider

Clinic Location/Address

Date seen at clinic **Time seen at clinic**

Instructions

Please outline the specific details of the problem and identify when the event(s) occurred. PLEASE BE SPECIFIC. Please include a statement regarding the outcome desired and what you believe Patient Plus can do to resolve your concern. If you have copies of documents, bills, checks or other correspondence related to this problem that may help in the resolution, please include them with this form.

Patient Signature - *I certify that this information is true and accurate*

Date