Patient Complaint/ Grievance Form

Our patients should have reasonable expectations of care and services provided to him or her while at Center for Sight. CFS intends to make available a means whereby differences and disagreements in ethical and professional conduct may be brought to a settlement fair to all parties' interests. We are committed to addressing situations when those expectations are not met in a timely, reasonable, and consistent manner.

Our administrative team and staff are all available to assist you with completing this form, filing a formal grievance over the phone, or to answer questions at (850) 476-9236. Please return this form to: Center for Sight ATTN: Complaints 6190 N Davis Hwy, Pensacola, FL 32504.

Name:_____ Date: _____

Address:_____

Telephone: _____ Date of Birth: _____

DETAILS OF YOUR COMPLAINT

(Please be as specific as possible with the following (1) please state your concern; (2) date of event; (3) time of event; (4) staff member(s) involved, and (5) location of event. Use the other side of this form if you need more room.

_____
_____
_____
_____
_____

Date: _____ _____
Signature of Patient or Legal Representative

If Legal Representative, state relationship _____

THIS SECTION IS TO BE COMPLETED BY THE REVIEWER

Date Received: _____ Reviewed by: _____

Reviewer's Comments:

_____
_____
_____

Date Patient was notified of resolution by mail to the address above or phone call to phone number above:

_____

Date: _____ Reviewer's Signature: _____