HEALTH & WELLNESS
Stigler - Eufaula - Sallisaw

Complaint Form

FOR OFFICE USE ONLY
Complaint #

Thank you for your recent visit to the Health and Wellness Center. We value you as a patient and want to ensure that our level of care and service met your needs. If any part of your visit was less than satisfactory, please complete the form below. Thank you for helping us evaluate and improve our services.

Date of Visit:

Health and Wellness Center visited: ***(please check which facility you visited)***

☐ **Sallisaw** ☐ **Stigler** ☐ **Eufaula**

Full Names(s) of Staff About Whom You Are Commenting:

Please describe your concern below:

Contact Information

<u>PLEASE NOTE:</u> Entering contact information is voluntary. However, if you have addressed an issue on this form that requires patient involvement to achieve resolution, be sure to fill in the information below so that the HWC staff will be able to contact you to ensure that resolution has been met.

Your Name: _____ _____ _____

Last Name *First Name* *Middle Initial*

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: *(mmddyyyy)* _____ **Home Phone:** _____ **Cell Phone:** _____

Email: _____

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Dependent Child** ☐ **Legal Guardian**

Patient Name: _____ _____ _____
(if different from above)

Last Name *First Name* *Middle Initial*

- *Filing a compliment or complaint is strictly voluntary, however, without the contact information requested above, we may be unable to adequately process your comment. We collect this information under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We will use the information you provided to determine how we will process and/or respond to your comment. The release of your records and personal information is solely for the purpose of investigation and proceedings related to the complaint you have submitted.*
- *Information submitted on this form is treated confidentially. Names or other identifying information about individuals are disclosed when it is necessary for investigation of health-related matters, possible health information privacy violations, for internal systems operations, or for routine uses, including disclosure for purposes association with health information and privacy compliance as permitted by law.*
- *By signing below, you acknowledge that a written record of this exchange will be kept in the named patient's confidential medical file at the Health and Wellness Center. It is illegal for a covered entity to intimidate, threaten, coerce, discriminate or retaliate against you for filing a complaint or for taking any other action should you elect to enforce your rights. Your are not required to sign this form to determine eligibility for health care benefits, to enroll for health care benefits, to receive health care coverage or to receive medical treatment.*
- *You have the right to revoke this authorization at any time by notifying the HWC in writing. The revocation is only effective after it is received and logged by the HWC. Any use or disclosure made prior to the revocation under this authorization will not be affected by such a revocation and will not have any effect on actions taken before the revocation is received.*
- *After completion of the form please send to:*
  Sallisaw Health and Wellness Center
  Teresa Noah, BS, RHIA, CTR, Quality Assurance/Performance Improved Coordinator
  1630 Kerr Blvd
  Sallisaw, OK 74955
- *By your signature below, you acknowledge that you understand these rights with regard to your Protected Health Information (PHI) and hereby voluntarily grant authorization to release this information for the purposes described herein.*

Signature: _____ **Today's Date** _____