FOR OFFICE USE ONLY
Complaint #

Thank you for your recent visit to the Health & 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 to evaluate and improve our services.

Date of Visit:

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

☐Checotah ☐Eufaula ☐McAlester ☐ Mobile Dental Unit ☐Poteau ☐Sallisaw ☐Stigler ☐Warner ☐Wilburton

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

Please describe your concern below:

PLEASE NOTE: 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.

Patient Name:

Last Name *First Name* *Middle Initial*

Address:

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

Date of Birth: *(mm/dd/yyyy)* **Home Phone:** **Cell Phone:**

Email:

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

Your 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 feedback. 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 & 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. You 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 Health & Wellness Center 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:*
  Health and Wellness Center
  Attention: Chief Operating Officer&/or CQI Coordinator
  PO Box 179
  Stigler, OK 74462
- *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:**