PATIENT GRIEVANCE FORM

All patient grievances are confidential. This report and any attachments are part of **Trails Edge Surgery Center** Grievance Policy and therefore protected confidential documents under the law. All grievances will be given serious attention.

This patient grievance form will be forwarded to the center leaders to address your concerns.

PERSON REGISTERING THE GRIEVANCE

Name: _____
Last First MI

Mailing Address: _____

_____
City State Zip

Patient Name: _____
Last First MI

Contact Phone Number: _____

Patient Date of Birth: _____ **Your Relationship to Patient**: _____

NATURE OF GRIEVANCE

Date of Service: _____ Account number: _____

Facility Name: _____

Please check the box that best describes the nature of your complaint/concern and provide details below:

☐ Balance Due
☐ Billed Charges/Services
☐ Adjustments
☐ Payments
☐ Refund Due
☐ Other_____

Describe problem or reason for complaint: _____

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Patient/Guardian/Representative Signature:_____ Date: _____

Email address Required to receive acknowledgement: _____

Please Mail to:
Trails Edge Surgery Center
Denise Melendez, CEO
28930 Trails Edge Blvd., Ste 100
Bonita Springs, FL 34134

********** FOR OFFICE USE ONLY **********

Date Received: _____

Routed to:

☐ Business Office Manager/CEO ☐ Central Billing Office (if applicable)

Acknowledgement sent by: ☐ Email ☐ Letter Date Sent: _____

*CEO/BOM Signature:*_____ *Date:*_____

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