



Patient Feedback Form

Note: To ensure the best possible experience for our patients, People's Center takes patient concerns very seriously. We will respond with a receipt acknowledging your complaint within 48 hours, at which point, we will begin investigating your complaint. We will inform you of our progress and the outcome as soon as possible.

Your Name: _____ Date: _____

Address: _____ Phone number: _____

Patient's Name: _____ Email address: _____

Relationship to Patient: self spouse child other _____

***Anonymous complaints will be accepted; however, failure to provide name may limit our investigation.**

Feedback is regarding:

front desk scheduling management

triage nurse physician laboratory

x-ray medical assistant billing

Other _____

Site: Family Dental Clinic Cedar Riverside Clinic TAMS Clinic Our Saviors Clinic

Date of occurrence: _____

Please provide a description of the issue in the space provided or attach a separate sheet (include names and dates when possible).

What result would you like from our review of your complaint?

By signing below, you authorize the Clinic Supervisor to share this information with the person or department named. If you do not authorize us to do so, our investigation may be limited.

Signature: _____ Date:

Please submit or mail completed form to our

Compliance Officer at: compliance@peoples-center.org