PATIENT GRIEVANCE FORM

All patient grievances are confidential. This report and any attachments are part of **Total 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		
			Σιμ		
Patient Name:	Last	First	MI		
Contact Phone Nu	mber:				
Patient Date of B	irth:	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:					

Email address Required to receive acknowledgement: Please Mail to: Total Surgery Center Nyleen Flores, CEO 130 Tamiami Trail North, Ste 210 Naples, FL 34102 Date Received: Mathematical Received: Business Office Manager/CEO CEO/BOM Signature: Date: Date:					
Email address Required to receive acknowledgement: Please Mail to: Total Surgery Center Nyleen Flores, CEO 130 Tamiami Trail North, Ste 210 Naples, FL 34102 Date Received: Manual Provide Manager/CEO Business Office Manager/CEO CEO/BOM Signature: Date: Date:					
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Please Mail to: Total Surgery Center Nyleen Flores, CEO 130 Tamiami Trail North, Ste 210 Naples, FL 34102 ***********************************	Patient/Guardian/Representative Signature:	Date:			
Total Surgery Center Nyleen Flores, CEO 130 Tamiami Trail North, Ste 210 Naples, FL 34102 Date Received:	Email address Required to receive acknowledgement:				
Date Received:	Total Surgery Center Nyleen Flores, CEO 130 Tamiami Trail North, Ste 210				
Routed to: Business Office Manager/CEO Central Billing Office (if applicable) Acknowledgement sent by: Email Letter Date Sent: CEO/BOM Signature: Date:	**************************************				
Business Office Manager/CEO Central Billing Office (if applicable) Acknowledgement sent by: Email Letter Date Sent: CEO/BOM Signature: Date:	Date Received:				
Acknowledgement sent by: Email Letter Date Sent:	Routed to:				
CEO/BOM Signature: Date:	Business Office Manager/CEO	 Central Billing Office (if applicable) 			
	Acknowledgement sent by: 🗌 Email 🗌 Letter	Date Sent:			
	CEO/BOM Signature:	Date:			