

KIMBALL HEALTH SERVICES PATIENT COMPLAINT FORM

INSTRUCTIONS

KIMBALL HEALTH SERVICES is committed to respecting your right to privacy of your personal health information. We take all complaints very seriously, and will not retaliate for filing a complaint. To file a complaint, complete this form and return it to the CEO.

NAME:	DATE OF INCIDENT:				
ADDRESS:					
CITY:	_ STATE:		ZIP CODE:		
TELEPHONE NUMBER:					
NATURE OF COMPLAINT:					
SIGNATURE			 ГБ		



		Fo	or Internal	Use Only		
INVESTI	GATION:					
Patient Con	tacted: Date		Time _		_	
RESOLU'	TION:					
Patient No	otified: Date			Time		
Name of I	Person Resolvi	ng Proble	em:			
				Code	Date of Service	Amount
PATIENT SAT	ISFIED: YES	□ NO	Credit Iss	sued:		
Patient/fam	ily notified of rig	ht to appea	al if unsatis	fied:		

When completed, this form is to be routed to The Outcomes Director for Quality Improvement and/or the Privacy Officer.