SCOTTSDALE EYE SURGERY CENTER, P.C.
GRIVANCE FORM

Scottsdale Eye Surgery Center, PC is committed to providing high-quality medical care to all patients. You may file a complaint/grievance with us if dissatisfied with any aspect of your care in person or with this form. Management and Quality Committee team will review and investigate submitted complaints/grievances and contact you within 30 days. You may submit this form to Scottsdale Eye Surgery Center, PC, 8414 N. 90th Street, Scottsdale, AZ 85258.
Or online to: info@scottsdaleeye.biz

Date: _____
Personal information: _____
Address: _____
Phone number: _____Email:_____
Notification preference: (mail or email)_____

Complaint/grievance information: Please check the box that best describes the nature of your complaint or grievance.

Date of complaint/grievance: _____

□ Substandard care □ Unprofessional conduct □ Access

□ Billing concern □ Registration concern □ Other_____

Detailed description of complaint/grievance: (including who was involved, what happened, when, where)

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Completing this form will not affect the care you receive, and all information will remain confidential.

Patients' signature: _____

2/09

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_____

_____****TO BE COMPLETED BY SCOTTSDALE EYE SURGERY CENTER****_____

Date complaint received:_____ Reviewed by:_____

Action taken:_____

_____

_____

Date patient notified: _____

Reviewer signature: _____