PATIENT COMPLAINT/GRIEVANCE FORM

AR Health is committed to providing high-quality medical care to all patients. You may file a complaint/grievance with AR Health if dissatisfied with any aspect of your care. Our executive team will review and investigate submitted complaints/grievances and contact you within 30 days. You may submit this form in person, by mail to AR Health, 500 West Third Street, Williamsport, PA 17701, or online at arhealthservices.org/patient-forms.

Personal information:

Patient name: _____

Address: _____

Phone number: _____ Email: _____

Notification preference (mail or email): _____

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

Date of incident: _____ Date of complaint/grievance: _____

- ☐ Substandard care
- ☐ Unprofessional conduct
- ☐ Other: _____
- ☐ Access
- ☐ Billing/registration concern

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

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

Patient's Signature: _____

********** **THIS SECTION IS TO BE COMPLETED BY THE REVIEWER** **********

Date complaint received: _____ Reviewed by: _____

Action taken: _____

Date patient notified: _____

Reviewer signature: _____