PATIENT COMPLAINT FORM

Section			
Patient Information	**Patient Name**		**Date of Birth**
	Street Address		**Apt.**
	City	**State**	**Zip**
	Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )
	E-mail address		
Subject of Complaint	**Provider's Name**		
	Street Address *253 East 142 Street*		
	City *Bronx*	**State** *New York*	**Zip** *10451*
	Work Phone (*718*) *306-6220*	**Home Phone** ( )	**Cell Phone** ( )

Nature of Complaint

Please check all that apply

☐ Quality of care	☐ Inappropriate prescribing	☐ Excessive test or treatment
☐ Misdiagnosis of condition	☐ Sexual contact with patient	☐ Failure to release patient records
☐ Substance abuse	☐ Insurance fraud	☐ Impairment/medical condition
☐ Advertising violation	☐ Misfilled prescription	☐ Patient abandonment/neglect
☐ Unlicensed	☐ Problem other than listed above ____________________	

Details of Complaint

Please give full details of your complaint/report: include facts, details, dates, locations, etc. Please attach copies of medical records, correspondence, contracts, and any other documents that will help support your complaint. (attach additional sheets if necessary).

Patient Signature ________________________________ **Date** ____________________

(Required to file complaint)

Please mail or bring this form to:
Bronx Health Center
253 East 142 Street
Bronx, NY 10451