ASSOCIATES IN FAMILY MEDICINE, P.C.

Quality Care for Life

Customer Service Feedback Form

Associates in Family Medicine is committed to providing quality healthcare for every patient and respecting your right to privacy of your personal health information. As an important part of the practice's Quality Improvement Program, Associates in Family Medicine will address any concerns from our patients in an effort to improve the care we provide.

Thank you for taking the time to fill out this form and return it to any of the Associates in Family Medicine locations, Attention: Office Manager.

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Date: _____

NATURE OF YOUR CONCERN OR COMPLIMENT:

☐ **HIPAA Violation** ☐ **Quality of Care** ☐ **Billing** ☐ **Customer Service**

DETAILS:

(Please be as specific as possible and include the following;

(1) please state your concern (2) date and time of event (3) location of event (4) staff member(s) involved

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INVESTIGATION, FOLLOW UP AND RESOLUTION:

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