North Star HEALTH

Formerly Springfield Medical Care Systems

Complaint / Grievance Form

Patient Information

Patient Name: _____

Address: _____

Telephone Number: _____

Best day / time to be reached: _____

Complaint Information

Name of Person Initiating Complaint: _____

Address: _____

Telephone Number: _____ Relationship to Patient: _____

Nature of Complaint

- ○ Appointment / Access
- ○ Medical Care
- ○ Problem with Provider
- ○ X-Ray
- ○ Problem with Staff
- ○ Referral
- ○ Medication
- ○ Policy / Procedure
- ○ Billing
- ○ Laboratory
- ○ Medical Records
- ○ Other: _____

Date & Time of Incident: _____

Names of Staff involved, if known: _____

In your own words, please tell us why you are not happy with the care or services you received:

_____

_____

_____

_____

As a result of your complaint, what would you like to see happen?

_____

_____

I understand the staff investigating this complaint may need to see and review health records. All information will be kept confidential. I further understand that this complaint / grievance will in no way affect any care provided.

Signature: _____ Date: _____

Thank you for taking the time to bring your complaint to our attention. You should receive a response within 30 days. Patients may mail all submissions to: North Star Health, Patient Relations Box #830, 100 River St., Springfield, VT 05156. This form can also be emailed to: PatientRelations@northstarfqhc.org