PAIN CARE & NATURAL MEDICINE CENTER OF CHARLESTON
Marc Dubick, DDS, MD
2097 Henry Tecklenburg Drive, Suite 203 West
Charleston, SC 29414
843-573-3444

COMPLAINT FORM

You have the right to file a complaint with Pain Care and Natural Medicine Center of Charleston about our privacy practice, our privacy policies or procedures, or our adherence to Federal or State privacy laws. We will investigate your complaint and will give you our written response. We will not require you to give up any rights you may have by law to file a complaint, and your filing of a complaint will not result in any retaliation by us against you. To exercise this right of complaint, please complete the sections below and return this form to us. We will assist you with any questions you may have with regard to completing the form. You may also file a complaint with the U. S. Department of Health & Human Services and we will provide you with the information to do so should you so choose.

PATIENT INFORMATION

Name: ____

Telephone: _____-_____-_____ FAX: _____-_____-_____ e-mail: _____________

Address: _______________________________ City: _______________ State: _____

Patient Account # __________________ Patient Social Security # _____ - ___ - ______

PATIENT COMPLAINT

(Describe your complaint): ____

____

____

(Describe how you would like the complaint resolved): ________________________________

____

____

I certify that this information is true and correct to the best of my knowledge

Patient's Signature: __________________________ Date: ______ - _____ - _____

If complaint is filed on behalf of a patient, please complete the following:
Personal Representative Signature: ____________________________

(Print Name): _______________ Relationship: ____________ Date: ____-____- ____

(You have a right to request a copy of this complaint)