SCHOOL OF OPTOMETRY
INDIANA UNIVERSITY
Bloomington

Patient Concern Form

Dear Patient, Indiana University School of Optometry is committed to providing you with the best experience possible. We encourage you feel free to voice any concerns, grievances, or recommendations you may have either by speaking directly with one of our staff members or filling out this Concern Form. No retaliatory action will ever be taken against you as a result of your voicing such a concern.

In order for us to best address your concern please fill out the information below as completely as possible. If a staff member is unable to directly address your concern at the time of service, the concern will be forwarded on to the appropriate manager who will investigate the concern, take any action necessary and follow up with you in writing or by telephone within three (3) business days. If there is no satisfactory resolution, the concern will be referred to the next level of management up to the Clinic Director.

Person submitting concern: _____Account #:_____

Patient Name (if different): _____ Patient Date of Birth: ___ / ___ / ____

Address: _____

Telephone: _____ E-mail Address: _____

Best way to reach you? _____ Best time to reach you? _____ _____

Details of concern (Please be as specific as possible, include the details of the situation, and the names of any individuals involved, if known). Feel free to attach additional sheets if needed.

Date of Concern: _____ Description of situation: _____

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Signature _____ **Date:** _____

Please turn this form in to a Staff Member or if you wish you can mail it to the following address:

Clinic Finance
Indiana University School of Optometry
800 E Atwater Ave, Bloomington, IN 47405
(812)-855-3670