

PATIENT FEEDBACK FORM

We appreciate that you have chosen us to partner with you to meet your health care needs. As we continue to evaluate and strive to improve operations, we encourage and value comments and suggestions from you.

Our mission is to be a model of integrated health care as the premier college health center in Ohio, providing comprehensive health and wellness care to promote retention and academic success.

One of our management team members will be happy to review your feedback via email, phone or by appointment.

This concern is regarding my bill? Yes or No **(circle one)**

This concern is regarding my care? Yes or No **(circle one)**

Did you discuss this concern with a member of your health care team? Yes or No **(circle one)**

Date of Occurrence? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize someone from University Health Services to contact me by phone at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR email at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What happened?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

Management Team response: (within 3 business days)

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