

APPOINTMENT SCHEDULING COMPLAINT FORM

TO: HMO Patient Services Representative or HMO Medical Director

_____ (Name)

_____ (HMO)

_____ (Address)

Patient Responsibility Statement

I requested an appointment with a doctor on the following dates:

_____ (date) _____ (date) _____ (date) _____ (date)

Patient Rights Violations

The appointment was not scheduled due to these problems (Check all that apply)

___ Appointment telephone lines were too busy to get through.

___ I was put on hold too long and had to hang up.

___ I was put on hold and was disconnected.

___ I left a message and no one called me back.

_____ (Name) refused to schedule an appointment without giving a reason.

_____ offered inconvenient appointment times, dates, and/or locations.

_____ refused to schedule an appointment with a doctor.

_____ ordered me to see a doctor other than the one of my choice.

_____ ordered me to see an inappropriately qualified provider.

Other problem(s): _____

Use back of form for additional comments.

Patient Satisfaction Request and Self-Protection Plan

Please contact me within **five (5) working days** to arrange an appointment with a doctor of my choice at a convenient time and location. Should you be uncooperative in complying with my request, I will enforce my healthcare rights.

Patient Signature

Date

City / State / Zip

_____ (Print name) (_____) _____ (Telephone)