Amery Hospital & Clinic
HealthPartners®

• GRIEVANCE/COMPLAINT •

Date of grievance/complaint: ___________________

Date of occurrence: _________________

Include name of patient involved and person making complaint

Name ___________________________________ Phone #: ________________

Name ___________________________________ Phone #: ________________

Department: ____________________________

Type of complaint (√ as many as applicable):

___Access ___Communication/Behavior

___Facility/Environment ___Benefit coverage/billing

___Waiting time ___Care provided

___Leave practice ___HIPAA

___Other:________________________

Comments/resolution/other information:

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Person receiving/handling complaint:____

Date of satisfactory resolution: ________________________

Return this form to Sandi Reed upon completion by mailing to: Amery Hospital & Clinic, 265 Griffin Street E, Amery, WI 54001.

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