UNICARE COMMUNITY HEALTH CENTER, INC.
PATIENT COMPLAINT FORM/ FORMULARIO DE QUEJA DEL PACIENTE

Patient Information/Información del Paciente

Full Name/Nombre Completo: _____

D.O.B./Fecha de Nacimiento: _____/_____/_____ Telephone Number/Teléfono: _____

Address/Domicilio: _____

Details of Complaint/Detalles de la Queja

Date of Occurrence/Fecha de la Ocurrencia: _____/_____/_____ Time (if known)/Hora (si se conoce): _____ AM / PM

Location (Department, Clinic, etc)/Ubicación (Departamento, Clínica, etc.): _____

Description of Complaint/Descripción de la Queja

Please describe what happened. Include any relevant details or concerns/Describa lo ocurrido. Incluye cualquier detalle o preocupación relevante.

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Authorization and Signature/Autorización y Firma

Patient Signature/Firma del Paciente: _____ Date/Fecha: _____/_____/_____

For Office Use Only

Received by (print name & title): _____ Date Received: _____/_____/_____

As required by the Health Information Portability and Accountability Act of 1996 you have a right to complain about our privacy policies, procedures or actions. This medical practice will not engage in any discriminatory or other behavior against you because of this complaint.

Rev. 05/2025