

#### DIVISION OF MEDICAL QUALITY ASSURANCE Consumer and Investigative Services

Health care practitioners are regulated by the Department of Health and the action which may be taken is administrative in nature, e.g., reprimand, fine, restriction of practice, remedial education, administrative cost, probation, license suspension or license revocation. The Department cannot represent you in civil matters to recover fees paid or seek remedies for injuries. You may wish to consult a private attorney regarding these matters.

### **COMPLAINT FORM INSTRUCTIONS**

The Department of Health investigates complaints and reports involving health care practitioners and enforces appropriate Florida Statutes.

#### ISSUES WHICH ARE NOT WITHIN THE AUTHORITY OF THE DEPARTMENT INCLUDE:

- \* Fee disputes (i.e. broken or missed appointments)
- \* Billing disputes (i.e., the amount a physician charges for services).
- Personality conflicts
- Bedside manner or rudeness of practitioners (such as the physician or his/her office staff's attitude or professionalism)

### HOW TO FILE A COMPLAINT/REPORT AGAINST A HEALTH CARE PRACTITIONER:

- To file a complaint/report, you must do so in a signed, written report. For your convenience you may use this form providing dates and details about your complaint.
- Use a separate complaint form for each practitioner you wish to file a complaint against.
- Be specific and include copies of pertinent medical records, correspondence, contracts, and any other documents that will help support your complaint.
- Medical records are needed to process your complaint. Since a health care practitioner cannot disclose his or her patient names or records with authorization, the Authorization for Release of Patient Information form included on page 3 must be completed and signed. **Signatures must be witnessed or notarized.**
- The Department will acknowledge receipt of your complaint or report by letter.
- If the allegations contained in your complaint/report are determined to be possible violations of applicable laws and rules, your complaint will be opened for investigation.
- Please note that if your complaint is assigned for investigation, a copy of the complaint form will be provided to the health care practitioner pursuant to Florida law.
- The Department <u>may</u> investigate an anonymous complaint if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is <u>substantial</u>, and if the department has reason to believe, after preliminary inquiry, that the violations alleged in the complaint are true.

If you have questions about the complaint process, contact the Consumer Services Call Center in Florida toll free at 1 (888) 419-3456, or the Consumer Services Unit at (850) 245-4339.



# HEALTHCARE PRACTITIONER COMPLAINT FORM

#### COMPLAINANT/REPORTER

Your Name:				
	Last	First	М.І.	
Address:				
	Street Address		Apartment/Unit #	
	City		State	ZIP Code
Home Telepho	one: ()	Work Telephone:	) В	Best Time to Call:
		ALTHCARE PRACTITIONER I		
Provider's				
Name:				
Practice	Last	First	М.І.	
Address:				
	Street Address		Apartment/Unit #	
	0.0		0/-/-	
Llama Talanka	City	Mark Talankana (	State	ZIP Code
Home Telepho	line. ()	Work Telephone: (	<u>)</u>	
Profession:		(i.e. doctor, dentist, nurse,	etc.)	
License Numbe		(if known)	n nat tha same as Car	naloja ost/Dos ostos)
	FORMATION (Cor	nplete this section if Patient is	s not the same as Cor	nplainant/Reporter)
Name of Patient:				
	Last	First	М.І.	
Address:				
	Street Address		Apartment/Unit #	
	City	Work	State	ZIP Code
Home Teleph	none: ( )	Telephone: (	)	
•	TIONSHIP TO PATIENT			
Self	Parent Son/Daughter	Spouse  Brother/Sister	🗌 Friend 🗌 Ot	her Practitioner
***	-	_		
	Guardian/provide court documents	Other		
NATURE OF	COMPLAINT/REPORT (Plea	ase check all that apply.)		
Quality of c	care	Inappropriate prescribing	Excessive test or t	treatment
Misdiagnos	sis of condition	Sexual contact with patient	Failure to release	patient records
□ Substance abuse □ In		Insurance fraud	Impairment/medical condition	
Advertising violation		Misfilled prescription	Patient abandonment/neglect	
Unlicensed	1	Problem other than listed above	9	
	tempted to contact the practitioner c			
-	be willing to testify if this matter goes			
-	nt involved criminal conduct, you sho	-		ave you contacted your
		] No	incement autionty. Th	ave you contacted your
If yes, state the name of the person or office that you contactedWhen did you make				
this contact?Please give case number if available ***NOTE: If other than patient or parent of a minor patient, please provide documentation indicating				
	nt of Legal Authority/Guardians			ninucating

ull Name:	Address:	Telephone Number:
		Prior Treating Subsequent Treating
ull Name:	Address:	Telephone Number:
		Prior Treating Subsequent Treating
ull Name:	Address:	Telephone Number:
		Prior Treating Subsequent Treating
VITNESSES (PLEASE O	GIVE FULL NAME, ADDRESS AND TELEF	PHONE NUMBER)
ull Name:	Address:	Telephone Number:
ull Name:	Address:	Telephone Number:
ull Name:	Address:	Telephone Number:
nedical records, corresponden dditional sheets if necessary). ] I have attached copies of me	ce, contracts, and any other documents	dates, locations, etc. Please attach copies of that will help support your complaint. (attach ts, and any other documents that will help suppo
nedical records, corresponden dditional sheets if necessary). ] I have attached copies of me	ce, contracts, and any other documents	that will help support your complaint. (attach
nedical records, corresponden dditional sheets if necessary). ] I have attached copies of me	ce, contracts, and any other documents	that will help support your complaint. (attach
nedical records, corresponden additional sheets if necessary).	ce, contracts, and any other documents	that will help support your complaint. (attach

#### WHAT WOULD SATISFY YOUR COMPLAINT?

Florida Statutes 837.06, False Official Statements: Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree.

Signature:

(Required to file complaint)

see road to quality health care MQA begins here

Please mail this form to: Florida Department of Health Consumer Services Unit 4052 Bald Cypress Way, Bin C-75 Tallahassee, Florida 32399-3275

Date:



# **AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION**

TO: Any and all treating health care practitioners or facilities

This authorization meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Law) found at 45 CFR, Part 164.

A photocopy of this document is as sufficient as the original.

This document authorizes any and all licensed health care practitioners, including but not limited to: physicians, nurses, therapists, social workers, counselors, dentists, chiropractors, podiatrists, optometrists, hospitals, clinics, laboratories, medical attendants and other persons who have participated in providing any health care service to me, to discuss any communication, whether confidential or privileged, and to provide full and complete patient reports and records justifying the course of treatment including but not limited to: patient histories, x-rays, examination and test results, reports or information prepared by other persons that may be in your possession and all financial records, to the Department of Health (or any official representative of the Department) pursuant to Section 456.057, Florida Statutes.

This document provides full authorization to the Department of Health (or any official representative of the Department) to use any of the aforementioned reports and information for reproduction, investigation or other use for licensure or disciplinary actions, and civil, criminal or administrative proceedings, as needed by the Department and may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy laws and regulation. This authorization is in effect until related disciplinary proceedings are concluded.

I understand that this authorization may be revoked upon my written request except to the extent that action has already been taken on this authorization.

Patient Name (Please Print)			
Patient Signature	Date of Birth	Social Security Number	Date
Name of Authorized Person Other than	Patient (Please Print)	Relationship	
Signature of Authorized Person Other	than Patient	-	
Witness Signature (if not notarized)		-	
STATE OF COUNTY OF Before me, personally appeared Whose identity is known to me by (type of identification) and who, acknow	viedges that his/her	signature appears above	
Sworn to or affirmed by Affiant before n	-	day of ,	20
NOTARY PUBLIC		My Commission Expires	
Name (please print)			
REV 060308		FOR OFFICIAL USE	ONLY



## <u>PARTA</u> COMPLAINTANT:

SUBJECT:

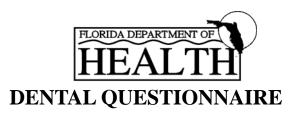
- 1. Has the treatment provided by the dentist been altered? If so by whom?
- 2. Please provide the following:
  - (a) Sign and date the enclosed Authorization for Release of Medical Information form. Please have your signature notarized or witnessed, and return the form to this office;

- (b) PATIENT RECORDS FROM THE DENTIST;
- (c) Name, address, and telephone number of any previous dentist(s); PLEASE INCLUDE PATIENT RECORDS
  - 1. Has the treatment provided by the dentist been altered? Yes/No
- (d) Name, address, and telephone number of subsequent dentist(s), including current dentist;

PLEASE INCLUDE PATIENT RECORDS

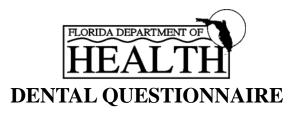
- (e) Factual narrative from subsequent dentist(s) as to his/her clinical observation, treatment plan, and treatment provided to date;
- (f) All x-rays; (from subject, previous and subsequent dentists)
- (g) Chronology of your treatment rendered, including month, day and year of treatment;
- (h) Detailed description of the treatment provided and the major complaint; (please use the attached chart)

PLEASE BE ADVISED THAT THE DEPARTMENT HAS NO AUTHORITY TO MANDATE A LICENSEE TO PROVIDE A REFUND. THESE MATTERS ARE CIVIL IN NATURE AND SHOULD BE ADDRESSED TO THE COURT WITH THE APPROPRIATE JURISDICTION.



<u>PART B</u> CON	IPLAINTANT:	
	SUBJECT:	
1 Maa traatmant ara		<u>URES</u>
r. was treatment pro	vided by a general dentist or a	i prostriodoniist?
<i>y</i> 1	sly worn denture: Yes/No d you wear the dentures?	
3. If you have previou	usly worn dentures, what type	are they?
	wearing the dentures in issue' upper	? Yes/No
a) Are they.	(a) full	(a) full
	(b) partial	(b) partial
b) If no, where issue?	e are the dentures in _	
. Have the dentures If yes, by whom?	been relined? Yes/No	
6. Have the dentures If yes, by whom?	been altered? Yes/No	
<ol> <li>If you answered N         <ul> <li>a) Are they:</li> </ul> </li> </ol>	O to question number 4, are y upper	ou currently wearing any dentures? Yes/No lower
-, · · · · · · · · · · · · · · · · · · ·	(a) full	(a) full
	(b) partial	(b) partial
b) Who provid	led these dentures?	· · ·
. What is your majo tc.)	r complaint regarding these d	entures? (i.e. too loose, too tight, causes sore sp

9. Has the dentist made any effort to resolve your complaints? Include the dates that adjustments or consultations occurred.



# <u>PART C</u> COMPLAINTANT:

SUBJECT:

# **CROWN & BRIDGE**

2. Please indicate, on the enclosed chart, which tooth/teeth are involved

3. What is your major complaint?

- 4. What type of crown did you expect to receive? (porcelaine, acrylic, etc.)
- 5. Are you satisfied with the appearance? Yes/No If not, explain why

6. Have you experienced problems with:

pain
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constant need for recementi	ng

uneven bite

cracking, chipping or breakage	looseness
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- \_\_\_\_\_ rough surfaces
  - other
- 7. Were you advised that the crown and/or bridge in questions was substandard? If so, by whom?



## <u>PART D</u> COMPLAINTANT:

SUBJECT:

# **ROOT CANAL THERAPY**

- 1. Was treatment provided by a general dentist or a endodontist?
- 2. Please indicate, on the chart provided, the tooth/teeth treated.
- Was an x-ray available for diagnosis? Yes/No If so, which dental office provided the x-ray? When was the x-ray taken?
- 4. Were any x-rays taken by the subject's office before, during or after completion of the Root Canal Therapy? If so when?
- 5. Was a rubber dam used? Yes/No
- 6. Was the Root Canal Therapy completed by subject? Yes/No If not by whom?
- 7. Were you advised of any necessary follow-up care? Yes/No If so, what?
- 8. Did the dentist advise you of any complications after the treatment? Yes/No
- 9. What is your major complaint with the Root Canal Therapy?
- 10. Were you advised that the Root Canal Therapy in question was substandard? Yes/No If so, by whom?

