



ZION Integrated Behavioral Health Services
 Administrative Office
 ATTN: Director
 2307 Olive St.
 Atlantic, Iowa 50022
 Phone: (712) 243-5091
 FAX: (712) 243-1337

Patient Complaint Form

To submit your complaint:

1. Fill out this form as complete as possible and mail or fax the **original complaint form** (not a copy) to ZION Recovery Services administrative office, attention: Director. Keep a copy for your records.
2. Enclose photocopies of any or all documents relevant to your complaint. **Do not send originals of these documents.**

Nature of Complaint (please present as many details in your description as possible) Attach additional pages if necessary:

List the names and contact information, if known, of all persons you believe may be responsible for this problem.

What solution do you desire:

Your Name: _____

Current Mailing Address: _____

City: _____ State: _____ Zip: _____

Your contact telephone number: _____

I hereby:

- affirm that this complaint is true and correct to the best of my knowledge

DATE: _____ SIGNED: _____

Agency use only

Reviewer Name: _____

Date: _____

Description of Outcome: _____

Action Plan: _____

Resolution of Complaint: _____

Patient Follow-up Date: _____

Patient Comments: _____
