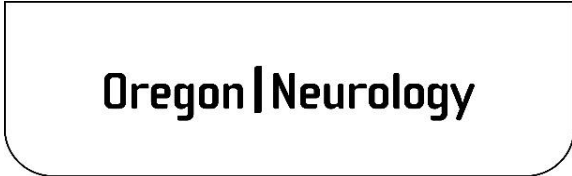


# Patient Feedback Form



Our goal is to provide comprehensive and compassionate care at every encounter. If you feel we've missed the mark, we'd value your feedback and ideas on how we could improve in the future.

**Person completing this form:** \_\_\_\_\_  
**Date of the concern:** \_\_\_\_\_  
**Phone #:** \_\_\_\_\_  
**Are you requesting a call back?** \_\_\_\_\_

**Patient information:**  
Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_

**Concern regarding:**  
Appointment or Scheduling  Care Provided  Other   
Statement or Billing  Orders or Referrals

**Brief statement of the issue you encountered:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize Oregon Neurology to review the above concern and take the action they feel is appropriate.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

*Return to: Oregon Neurology, ATTN: Operations Team, 1 Hayden Bridge Way, Springfield, OR 97477*