



Peter Hoffmann DMD PC

COMPLAINT

TO THE PATIENT:

You have the right to file a complaint with us about our privacy practices or our compliance with our Notice of Privacy Practices, our Privacy Policies and Procedures, or federal or state privacy rules or law. We will not require you to waive any right you may have under federal or state privacy or other law to file your complaint, nor will filing your complaint adversely affect our treatment of you. To exercise this right, please complete, sign and date Sections A and B, then submit this complaint to:

Contact Persons: Cheryl Cook or Laura Renner
Telephone: 814-726-3630 **Fax:** 814-726-9887
Email: SmileCentral@DrPeterHoffmann.com
Address: 211 Market Street, Warren PA 16365

You may, in addition or in the alternative to filing a complaint with us, file a complaint with the US Department of Health and Human Services. For information on the procedures for doing that, please contact us at the above location.

SECTION A:

PATIENT LODGING COMPLAINT

Name: _____
Address: _____
Telephone: _____
Email: _____
Birthdate: _____ Social Security Number: _____

SECTION B:

PATIENT'S COMPLAINT

Please give a concise, plain statement of your complaint:

Please give a concise, plain statement of the resolution you seek for your complaint:

SECTION C:
PATIENT'S SIGNATURE

I certify that the statements made in this complaint are true and correct to the best of my information and belief.

Patient's Signature Date

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Signature of Representative of Patient Date

State Relationship to Patient

YOU ARE ENTITLED TO A COPY OF THIS COMPLAINT