Date Submitted: ____/____/____

alma street MEDICAL

PAYMENT DISPUTE FORM

Title: Mr / Mrs / Miss / Ms / Dr Date of Birth: ____/____/_____

Surname: _____ Given Names: _____

Address _____

Phone (home) _____(work) _____Mobile _____

Email: _____Preferred contact method: ☐ Home ☐ Work ☐ Mobile ☐ Email

I am lodging this complaint on behalf of: (please circle) **Myself** OR **Another person**

If lodging a complaint on behalf of another person, please complete as much detail in the section below.

Details of person who received the service:

Title: Mr / Mrs / Miss / Ms / Dr Date of Birth: ____/____/_____

Surname: _____ Given Names: _____

Address _____

Phone (home) _____ (work) _____Mobile _____

Email: _____

DATE OF VISIT: ____ /____ /____

Please provide the details of your query in the box provided below:

PLEASE SUBMIT YOUR FORM TO RECEPTION. THE PRACTICE MANAGER WILL CONTACT YOU WITHIN SEVEN (7) BUSINESS DAYS TO DISCUSS YOUR COMPLAINT.