



3900 Clark Road Suite B5, Sarasota, FL 34223
941.366.0801 | www.rightaccordhealth.com

CLIENT COMPLAINT FORM

Date: _____

Client Name: _____

Caregiver Name: _____

Reason(s) for this complaint: (Please provide as much information as possible. Feel free to attach additional information to this form regarding the situation).

Have you confronted the caregiver regarding the situation?
Y N

Client Signature: _____ Date: _____

Office Use Only

Received By: _____ Date: _____

Follow-Up with Patient: Y N

Follow-Up with Caregiver: Y N

Notes Regarding Situation: _____
