Patient Feedback Form

Oregon | Neurology

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