The Door – A Center of Alternatives, Inc.
Adolescent Health Center

PATIENT FEEDBACK FORM

Contact Info

Patient Name:_____ **Door ID #:**_____

Email:_____ **Phone #:**_____

☐ **Check here if you do not want to provide contact info**

Category

Please check all that apply:

☐ **Clinical Care** ☐ **Customer Service** ☐ **Confidentiality/HIPAA** ☐ **Security/Lost Item**

☐ **Other (please describe):** _____

Feedback

Date/Time of event: _____

Name of Staff Involved:_____

Description of event:_____

_____

_____

_____

_____

_____

(Please continue on a separate sheet if necessary)

Desired Outcome:_____

_____

I understand that staff investigating this my feedback may need to see and review health records, and I understand all information will be kept confidential. I further understand that this feedback will in no way affect any care provided at the Adolescent Health Center.

Patient Signature: _____ **Date:** _____

Thank you for taking the time to bring your complaint to our attention.
You should receive a response within 5 business days.

Please return the form by:

- Mail – The Door AHC, Attn: Patient Feedback, 121 Avenue of the Americas, New York, NY 10013
- Email – PatientFeedback@door.org – Subject Line: Patient Feedback
- Fax – 212-941-9614 - Attn: Patient Feedback