DIVISION OF MEDICAL QUALITY ASSURANCE
Enforcement Program

Health care practitioners are regulated by the Department of Health and the action which may be taken is administrative in nature, e.g., reprimand, fine, restriction of practice, remedial education, administrative cost, probation, license suspension or license revocation. The Department cannot represent you in civil matters to recover fees paid or seek remedies for injuries. You may wish to consult a private attorney regarding these matters.

The Department of Health investigates complaints and reports involving health care practitioners and enforces appropriate Florida Statutes.

ISSUES WHICH ARE NOT WITHIN THE AUTHORITY OF THE DEPARTMENT INCLUDE:

- **Fee disputes** (i.e. broken or missed appointments)
- **Billing disputes** (i.e., the amount a physician charges for services).
- **Personality conflicts**
- **Bedside manner or rudeness of practitioners** (such as the physician or his/her office staff's attitude or professionalism)

HOW TO FILE A COMPLAINT/REPORT AGAINST A HEALTH CARE PRACTITIONER:

- To file a complaint/report, you must do so in a signed, written report. For your convenience you may use this form providing dates and details about your complaint.
- Use a separate complaint form for each practitioner you wish to file a complaint against.
- Be specific and include copies of pertinent medical records, correspondence, contracts, and any other documents that will help support your complaint.
- Medical records are needed to process your complaint. Since a health care practitioner cannot disclose his or her patient names or records without authorization, the Authorization for Release of Patient Information form included on page 3 must be completed and signed. **Signatures must be witnessed or notarized.**
- The Department will notify you in writing of the status of your complaint throughout the process. Please advise us of any address change.
- If the allegations contained in your complaint/report are determined to be possible violations of applicable laws and rules, your complaint will be opened for investigation.
- Please note that if your complaint is assigned for investigation, a copy of the complaint form will be provided to the health care practitioner pursuant to Florida law.
- The Department may investigate an anonymous complaint if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the department has reason to believe, after preliminary inquiry, that the violations alleged in the complaint are true.
- If you are reporting Medicaid Fraud, you may be entitled to a reward through the Office of the Attorney General. For information and to report Medicaid Fraud, please contact the Attorney General's Fraud Hotline by calling 1-866-966-7226 or online at http://ahca.myflorida.com and clicking the "Report Fraud" button.

HEALTHCARE PRACTITIONER COMPLAINT FORM

COMPLAINANT/REPORTER

Your Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Telephone: (____)_____ Work Telephone: (____)_____ **Best Time to Call:** _____

SUBJECT OF COMPLAINT/REPORT HEALTHCARE PRACTITIONER INFORMATION

Provider's Name: _____
Last *First* *M.I.*

Practice Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Telephone: (____)_____ Work Telephone: (____)_____

Profession: _____ **(**i.e. doctor, dentist, nurse, etc.)

License Number: _____ (if known)

PATIENT INFORMATION (Complete this section if Patient is not the same as Complainant/Reporter)

Name of Patient: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Telephone: (____)_____ Work Telephone: (____)_____

YOUR RELATIONSHIP TO PATIENT

☐ Self ☐ Parent ☐ Son/Daughter ☐ Spouse ☐ Brother/Sister ☐ Friend ☐ Other Practitioner

***☐ Legal Guardian/provide court documents ☐ Other _____

NATURE OF COMPLAINT/REPORT (Please check all that apply.)

☐ Quality of care ☐ Inappropriate prescribing ☐ Excessive test or treatment
☐ Misdiagnosis of condition ☐ Sexual contact with patient ☐ Failure to release patient records
☐ Substance abuse ☐ Insurance fraud ☐ Impairment/medical condition
☐ Advertising violation ☐ Misfilled prescription ☐ Patient abandonment/neglect

☐ Unlicensed ☐ Problem other than listed above _____

Have you attempted to contact the practitioner concerning your complaint? ☐ Yes Date:_____ ☐ No

Would you be willing to testify if this matter goes to a formal hearing? ☐ Yes ☐ No

If the incident involved criminal conduct, you should contact your local law enforcement authority. Have you contacted your local law enforcement authority? ☐ Yes ☐ No

If yes, state the name of the person or office that you contacted. _____When did you make this contact?_____Please give case number if available._____

***NOTE**: If other than patient or parent of a minor patient, please provide documentation indicating appointment of Legal Authority/Guardianship or Personal Representative.

PLEASE LIST ANY PRIOR AND/OR SUBSEQUENT TREATING PRACTITIONERS RELATIVE TO YOUR COMPLAINT.

Full Name: _____ Address: _____ Telephone Number: _____

☐Prior Treating ☐Subsequent Treating

Full Name: _____ Address: _____ Telephone Number: _____

☐Prior Treating ☐Subsequent Treating

Full Name: _____ Address: _____ Telephone Number: _____

☐Prior Treating ☐Subsequent Treating

WITNESSES (PLEASE GIVE FULL NAME, ADDRESS AND TELEPHONE NUMBER)

Full Name: _____ Address: _____ Telephone Number: _____

Full Name: _____ Address: _____ Telephone Number: _____

Full Name: _____ Address: _____ Telephone Number: _____

Please give full details of your complaint/report: include facts, details, dates, locations, etc. Please attach copies of medical records, correspondence, contracts, and any other documents that will help support your complaint. (attach additional sheets if necessary).

☐ **I have attached copies of medical records, correspondence, contracts, and any other documents that will help support your complaint.**

WHAT WOULD SATISFY YOUR COMPLAINT?

Florida Statutes 837.06, False Official Statements: Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree.

Signature: _____ Date: _____

(Required to file complaint)

the road to quality health care
MQA
begins here

Please mail this form to:
Florida Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C-75
Tallahassee, Florida 32399-3275

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

TO: Any and All Treating Health Care Practitioners or Facilities:

This authorization meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Law) found at 45 CFR, Part 164.

A photocopy of this document is as sufficient as the original.

This document authorizes any and all licensed health care practitioners, including but not limited to: physicians, nurses, therapists, social workers, counselors, dentists, chiropractors, podiatrists, optometrists, hospitals, clinics, laboratories, medical attendants and other persons who have participated in providing any health care or service to me, to discuss any communication, whether confidential or privileged, and to provide full and complete patient reports and records justifying the course of treatment including but not limited to: patient histories, x-rays, examination and test results, HIV, mental health, drug abuse treatment, psychiatric and psychological records, reports or information prepared by other persons that may be in your possession and all financial records, to the Department of Health (or any official representative of the Department) pursuant to Section 456.057, Florida Statutes.

This document provides full authorization to the Department of Health (or any official representative of the Department) to use any of the aforementioned reports and information for reproduction, investigation or other use for licensure or disciplinary actions and civil, criminal or administrative proceedings, as needed by the Department and may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy laws and regulation.

By signing below, the patient understands, acknowledges and authorizes the Department to release their identity and medical records to law enforcement and other regulatory agencies in appropriate circumstances at the departments' discretion.

I understand that this authorization may be revoked upon my written request except to the extent that action has already been taken on this authorization.

_____
Patient Name (Please Print)

_____
Patient Signature D.O.B. Social Security Number Date

_____ _____
Name of Authorized Person other than Patient (Please Print) Relationship

_____
Signature of Authorized Person Other than Patient

STATE of _____ COUNTY of _____

Before me personally appeared _____whose identity is known to me by _____ _____(type of identification) and who acknowledges that his/her signature appears above.

Sworn to or affirmed by Affiant before me this ___ day of_____, 20_____

_____ _____
NOTARY PUBLIC - State of Florida My Commission Expires

_____ _____
Type or Print Name Witness Signature (if not notarized)

DOH USE ONLY

Reference Number:
_____--_____

DENTAL QUESTIONNAIRE

PART A **COMPLAINANT:** _____

SUBJECT: _____

1. Has the treatment provided by the dentist been altered? If so by whom?

_____

2. Please provide the following:
   (a) Sign and date the enclosed Authorization for Release of Medical Information form. Please have your signature notarized or witnessed, and return the form to this office;
   (b) PATIENT RECORDS FROM THE DENTIST;
   (c) Name, address, and telephone number of any previous dentist(s);
   PLEASE INCLUDE PATIENT RECORDS
      1. Has the treatment provided by the dentist been altered? Yes/No

      _____

      _____

      _____

   (d) Name, address, and telephone number of subsequent dentist(s), including current dentist;
   PLEASE INCLUDE PATIENT RECORDS

      _____

      _____

      _____

   (e) Factual narrative from subsequent dentist(s) as to his/her clinical observation, treatment plan, and treatment provided to date;
   (f) All x-rays; (from subject, previous and subsequent dentists)
   (g) Chronology of your treatment rendered, including month, day and year of treatment;
   (h) Detailed description of the treatment provided and the major complaint; (please use the attached chart)

PLEASE BE ADVISED THAT THE DEPARTMENT HAS NO AUTHORITY TO MANDATE A LICENSEE TO PROVIDE A REFUND. THESE MATTERS ARE CIVIL IN NATURE AND SHOULD BE ADDRESSED TO THE COURT WITH THE APPROPRIATE JURISDICTION.

DENTAL QUESTIONNAIRE

PART B **COMPLAINANT:** _____

SUBJECT: _____

DENTURES

1. Was treatment provided by a general dentist or a prosthodontist?

_____

2. Have you previously worn denture: Yes/No
   If so, how long did you wear the dentures? _____

3. If you have previously worn dentures, what type are they?

_____

4. Are you currently wearing the dentures in issue? Yes/No
   a) Are they: _____ upper _____ lower
   (a) full _____ (a) full _____
   (b) partial _____ (b) partial _____
   b) If no, where are the dentures in issue? _____

5. Have the dentures been relined? Yes/No
   If yes, by whom?

_____

6. Have the dentures been altered? Yes/No
   If yes, by whom?

_____

7. If you answered NO to question number 4, are you currently wearing any dentures? Yes/No
   a) Are they: _____ upper _____ lower
   (a) full _____ (a) full _____
   (b) partial _____ (b) partial _____
   b) Who provided these dentures? _____

8. What is your major complaint regarding these dentures? (i.e. too loose, too tight, causes sore spots, etc.)

_____

9. Has the dentist made any effort to resolve your complaints? Include the dates that adjustments or consultations occurred.

_____

DENTAL QUESTIONNAIRE

PART C **COMPLAINANT:** _____

SUBJECT: _____

CROWN & BRIDGE

1. Was treatment provided by a general dentist or a prosthodontist?

   _____

2. Please indicate, on the enclosed chart, which tooth/teeth are involved

   _____

3. What is your major complaint?

   _____

4. What type of crown did you expect to receive? (porcelaine, acrylic, etc.)

   _____

5. Are you satisfied with the appearance? Yes/No
   If not, explain why

   _____

6. Have you experienced problems with:

   _____ pain
   _____ constant need for recementing
   _____ cracking, chipping or breakage
   _____ rough surfaces
   _____ other _____
   _____ uneven bite
   _____ recurrent decay
   _____ looseness

7. Were you advised that the crown and/or bridge in question was substandard?
   If so, by whom?

   _____

DENTAL QUESTIONNAIRE

PART D **COMPLAINANT:** _____

SUBJECT: _____

ROOT CANAL THERAPY

1. Was treatment provided by a general dentist or an endodontist?

   _____

2. Please indicate, on the chart provided, the tooth/teeth treated.

3. Was an x-ray available for diagnosis? Yes/No
   If so, which dental office provided the x-ray? _____
   When was the x-ray taken? _____

4. Were any x-rays taken by the subject's office before, during or after completion of the Root Canal Therapy?
   If so when? _____

5. Was a rubber dam used? Yes/No

6. Was the Root Canal Therapy completed by subject? Yes/No
   If not by whom? _____

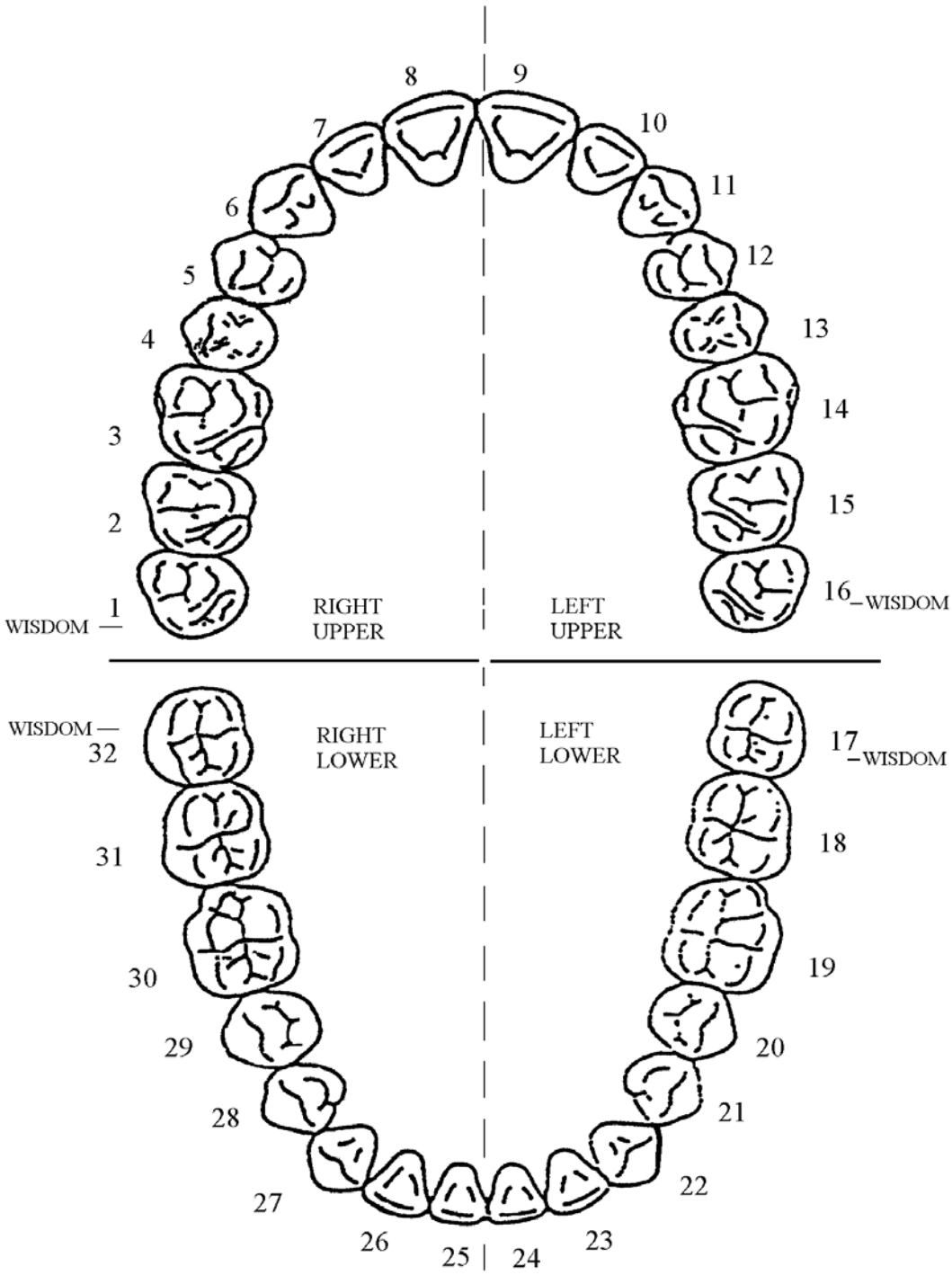
7. Were you advised of any necessary follow-up care? Yes/No
   If so, what? _____

8. Did the dentist advise you of any complications after the treatment? Yes/No

9. What is your major complaint with the Root Canal Therapy?

   _____

10. Were you advised that the Root Canal Therapy in question was substandard? Yes/No
    If so, by whom? _____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