Health Services

CLIENT RELATIONS FORM

LOS ANGELES LGBT CENTER

Please fill out this form as completely as possible. Your concern will be documented and reported, and then it will be forwarded to the Quality Coordinator and to the appropriate management staff for review. Someone will contact you, if indicated.

Client Name: ______________________________ Date of Incident: ____________________________

Phone Number: ____________________________

Nature of Concern/Problem

- ☐ Appointment Access
- ☐ Telephone Callback
- ☐ Quality of Care
- ☐ Rules or Regulations
- ☐ Referral
- ☐ Wait Time
- ☐ Problem with Staff
- ☐ Billing
- ☐ Other: ____________________________________

Describe your concern

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CLIENT RELATIONS FORM	**Name:** **PF#:**

Health Services

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Client Signature_____ Today's Date _____