

NORTH VALLEY MEDICAL ASSOCIATION

1670 Market Street, Suite 118

Redding, CA

Telephone 530.247.0293

COMPLAINT FORM

The North Valley Medical Association (NVMA) is a non-profit, private organization of physicians who volunteer their time to maintain quality medical care and good physician-patient relationships in the North State.

If you have a complaint with a physician please first discuss the matter with your physician before submitting this form to the NVMA. Most physicians wish to resolve physician patient matters whether they involve financial or quality of care concerns. If the treating physician is not a member of the NVMA, our ability to be of service will depend upon the willingness of the physician to participate in our process.

If you have already contacted your physician and are unable to resolve this matter, by completing and signing this form, you agree to voluntarily participate in our review process. A copy of your complaint will be sent to your physician and this matter will be directed to the proper committee for review. This process takes approximately eight weeks. You will be notified in writing of the committee's opinion, which is advisory only.

Please note that the Medical Board of California is the only authority in the state that may take disciplinary action against the license of the physician to whom your complaint relates. The toll-free phone number of the Medical Board is 800-633-2322, and the Medical Board is located at 1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236.

| | |
|----------------------|---------------------|
| Patient's Name _____ | Doctor's Name _____ |
| Address _____ | Address _____ |
| Telephone _____ | Telephone _____ |

Authorization: For the purpose of reviewing the dispute as stated below, I hereby authorize the doctor whose name I have written above to testify as to and to reveal any diagnosis, treatment, prognosis, medical records, xrays, or other information that concerns me and relates to the dispute described below to the NVMA. (Disputes will not be reviewed without the patient's signature). I also authorize the NVMA to release a copy of this form with any and all attachments to the above-named physician. This authorization shall be valid until a date two years after the date hereof.

Patient's Signature _____ Date _____

Please state your complaint briefly and attach photocopies of any billings or correspondence to which you refer (do not send originals). Your complaint must be typed, or printed clearly in blank ink only.

