

In keeping with Civil Code 43.96, please be advised that while the Stanislaus Medical Society's Public Service Committee will review your concern and advise you of its finding, it has no authority to take action against a physician's license. "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 number of the Medical Board of California is (800) 633-2322, and the Medical Board is located at 1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236. Please be advised that if you seek the advice, or have retained an attorney, the Stanislaus Medical Society's Public Service Committee will be unable to hear your complaint. The purpose of the Committee is to handle resolution of non-judicial matters."

PATIENT EXPERIENCE RECORD

The Stanislaus Medical Society (SMS) is a non-profit organization of physicians and surgeons, dedicated to maintaining quality medical care and improving patient relationships. SMS has a variety of committees volunteering their time toward these goals.

It is recommended that you personally discuss the issue with your physician before completing and returning this form. In most instances this communication resolves the problem.

If the treating physician is not an SMS member, our ability to be of service may be limited but, in the interest of improving patient relationships, we will still process your complaint. In all cases, even if the physician in question is a member of the SMS, the opinion of the Committee will be advisory only. SMS has no power to require you or your physician to accept its advice.

ACTION: This matter will be directed to the proper committee for review. You will be advised when they have rendered an opinion. Please allow 6-12 weeks for completion of the review process.

Please download the following form, complete the necessary information for our Review Committee [print or type] and return to the Stanislaus Medical Society at P.O. Box 576007, Modesto CA 95357-6007. The more clearly you can describe the situation or problem, the more effective the review can be.

Patient Name:	Physician Name:
Address:	Address
City:	City:
Zip:	Zip:
Home Tel:	Work Tel:

PARENT/GUARDIAN [if patient is less than 18 years old]

Name:	
Address:	
City:	
Home Tel:	Work Tel:

Please answer the following questions as detailed as you can.

1. What was the date you first felt there was a problem? _____

2. Have you contacted the physician in question? () Yes () No

If yes, give date (s): _____

3. Method used? Check One () Telephone () Letter () Other/Describe

4. Did the physician in question respond? () Yes () No

If yes, what action was taken?

5. Have you ever been examined or treated by another Physician relative to your problem? () Yes
No () If yes, give full name of physician:

6. Have you voiced concern to any other agency or organization? () Yes () No

If yes, please indicate to whom:

7. Have you contacted an attorney or filed a claim in Small Claims Court? () Yes () No

8. Can you suggest a fair solution to the problem?

Briefly describe your concern(s). Please be specific; include all that you can remember about dates, places and names. Attach legible copies of all itemized bills and pertinent documents, if applicable, to your complaint. If you need more space, use additional sheets and attach them to this form. Use additional paper if necessary.
Please print clearly or type.

AUTHORIZATION:

For the purpose of reviewing the above-described matter, I _____, being the patient or legal guardian of same, hereby authorize _____ M.D., to release information relative to any diagnosis, treatment, prognosis, medical records, x-rays or other information which relates to the above-described matter to the Stanislaus Medical Society. I also authorize the Stanislaus Medical Society to release a copy of this form (Patient Experience Record) with any and all attachments to the physician in question. I understand this authorization will be valid until a date two (2) years after the date hereof. I certify that all information which I have given herein to be true, correct, and complete to the best of my knowledge.

Signature: _____ Date: _____