The Richland Hospital, Inc.

Muscoda Health Center
Spring Green Medical Center
Divisions of The Richland Hospital, Inc.

Patient Concern / Compliment Form

Patient ______________________ Date of Birth ______________________

Street Address ______________________ Phone ______________________

City ______________ State ______________ Zip ______________

Department ______________________ Physician ______________________

Clinic ______________________ Date(s) of Service ______________________

CONCERN / COMPLIMENT:

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(Additional space available on other side)

If you have a concern, have you spoken to anyone at the hospital or clinic about it? ☐ Yes ☐ No

If yes, who did you speak with? ______________________________________

Date ______________________ Signature ______________________

www.richlandhospital.com

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