OHIO STATE BOARD OF OPTOMETRY

PATIENT COMPLAINT FORM

Date: _____

Name of Complainant: _____

Address: _____
street city state zip

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

Email address: _____

Complaint against: _____

Address: _____

Telephone: (____) _____

Nature of complaint: _____

_____

_____

_____

Date(s) on which optometric services were performed: _____

Nature of optometric services performed: _____

_____

_____

_____

How long did the eye examination last? _____

Eyeglasses or contact lens examination? _____

If specific promises of treatment were made, please specify: _____

_____

_____

If specific promises were made or implied which were not fulfilled, please specify:

_____

_____

_____

Were you informed by the examining optometrist that optometric treatment might not be successful?

_____

Amount Paid: Examination $_____ Glasses/Contact Lenses $_____

Were there any witnesses to the optometric services performed or promises of treatment made? _____ If so, please indicate:

Name: _____

Address: _____
street city state zip

If your complaint involves prescribed eyeglasses or contact lenses:

A. In what way(s) are the lenses unsatisfactory: _____

_____

_____

B. If the problem is vision:

1. Do you have difficulty seeing <u>distance</u>? (greater than 10 feet) _____

2. Do you have difficulty with <u>near</u> vision? (difficulty in reading a newspaper, threading a needle, etc.) _____

C. Are the eyeglasses uncomfortable? _____

1. Does the lens "pull" your eyes or cause eye strain? _____

2. Do the frames fit? _____

D. Did the optometrist who examined your eyes also furnish the lenses? _____

If the answer is no, please provide the following:

1. A copy of the optometrist's prescription.

2. Name of person or firm providing eyeglasses/contact lenses: _____

Address: _____
street city state zip

Telephone: ( ) _____

3. Brand name of contact lens, if available: _____

Type of contact lens; daily wear, disposable, hard, etc.: _____

4. Type of eyeglasses; monovision, bifocal, trifocal, etc.: _____

E. Did the problem involve the diagnosis, treatment or cure of any disease, injury or other abnormal condition of the eye? _____

1. What was the diagnosis of the optometrist? _____

2. Did the optometrist prescribe any medication; oral, drops, or ointment? _____

Did you consult another eye doctor for a second opinion? _____ If so, what date? _____

If so, please indicate:

Name: _____

Address: _____
street city state zip

Telephone: ( ) _____

Nature of advice of second eye doctor: _____

_____

_____

Medical:

A. General state of health: Good ____ Fair ____ Poor ____

B. Are you aware of any medical problem which may affect your eyes? (i.e. diabetes, circulatory problems, high blood pressure, etc.) _____

C. Are you taking any prescribed medication on a regular basis? _____
If yes, please list all medications and condition being taken for below.

_____

_____

Working through the Ohio State Board of Optometry, what do you think would be a fair solution to your complaint? _____

_____

_____

_____

Please Note:

If the Ohio State Board of Optometry should find grounds for an Administrative Hearing, it will be necessary for you to appear as a witness under subpoena.

Attempt to keep the communication lines open with the optometrist involved in your complaint. At any stage of the complaint investigation should you resolve the problem, please notify the Ohio State Board of Optometry so that appropriate action may be taken.

Information on your complaint will be released to the optometrists against whom you have made the complaint. It will be fully reviewed by a Board member to see if any Ohio Optometry Laws or Administrative Rules have been violated. Once this procedure has taken place, you will be informed, in writing, of the disposition of your complaint.

Please complete those captions that apply to your complaint and sign the enclosed Release of Optometric/Medical Records form and return them together to:

Ohio State Board of Optometry
77 S. High St., 16th Floor
Columbus, Ohio 43215-6108
1-888-565-3044

_____
(signature of person filing complaint)

You may use separate sheets of paper for any additional comments you may wish to make.

OHIO STATE BOARD OF OPTOMETRY
77 S. HIGH ST., 16TH FLOOR
COLUMBUS, OHIO 43215-6108

RELEASE OF OPTOMETRIC/MEDICAL RECORDS

I hereby authorize and request any optometrist and/or personal physician of _____ (print your name here) to release to the Ohio State Board of Optometry any information, files, or medical records requested by the Ohio State Board of Optometry in connection with my physical health, optometric examination, or other health problems.

I further authorize the Ohio State Board of Optometry to release to other organizations, groups or individuals involved in the litigation or investigation of my complaint any information which is material to the complaint investigation or material to my health or visual care.

A copy of this authorization will have all the force and effect of the original.

Must be Signed and Notarized

_____ _____
Complainant's Signature Date
(Must be signed in the presence of a notary)

State of _____

County of _____

Subscribed and sworn to before me this _____ day of _____, _____.

_____
Signature of Notary Public

NOTARY SEAL

_____
My Commission Expires

FORM OPT 1013 Revised 11-4-13