PATIENT REQUEST FOR MEDIATION

Please complete this form and return to the address listed below. Please note the following:
While a refund of charges is one of the options that **may** be recommended by the mediator, requests for refunds to you or to another dentist should not be made in writing on this form. Upon receipt of this completed form, a mediator will be assigned and will contact you within three weeks to help resolve the issue. The patient relations/peer review process was not designed to handle every type of situation and cannot consider cases that are in litigation or if legal intervention on the part of either party is initiated, dentist to dentist complaints, alleged fraud, and other violations of State Dental Practice Acts.
MAIL THIS FORM TO:
Patient Relations Committee, c/o Northern Virginia Dental Society, 4330 Evergreen Lane, Suite N, Annandale, VA 22003

PATIENT INFORMATION:

Date_____

NAME_____ PHONE_____

ADDRESS_____

CITY_____STATE_____ZIPCODE_____

NAME OF DENTIST:

NAME_____ PHONE_____

ADDRESS_____

CITY_____STATE_____ZIPCODE_____

DATE OF LAST APPOINTMENT _____

PLEASE DESCRIBE THE PROBLEM SPECIFIC TO THE DENTAL TREATMENT RECEIVED:

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Please provide a phone number and the best time of day for the mediator to contact you:

Day phone_____ Time_____

Evening phone_____ Time_____

By signing and submitting this form, you are saying that you agree with the following statement:

In order that a complete review be performed, I authorize the release to this committee of any dental records or information by anyone who has examined me previously. I further give my permission for the committee to perform a clinical examination if necessary.

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(Signature)