THE STATE BOARD OF ORTHOTICS, PROSTHETICS AND PEDORTHICS
77 South High Street, 18th floor Columbus, OH 43215-6108
Telephone: 614-466-1157 Fax: 614-387-7347
www.opp.ohio.gov

Complaint Form

(please print or type)

I. Complaint filed by:

Your name: _____

Your address: _____

_____

Home phone: (_____) _____ - _____ Work phone: (_____) _____ - _____

e-mail: _____

II. Your "status":

☐ Consumer ☐ Applicant ☐ Licensee ☐ Other Health Professional

☐ Other: _____

III. General subject matter of complaint:

☐ Unlicensed practice ☐ Level of care ☐ Billing

☐ Other: _____

_____

IV. Complaint is against:

Practitioner: _____

Place of business: _____

Address: _____

_____

Telephone: (_____) _____ - _____

Last date of service: _____ (next page, please)

V. Narrative statement of complaint (attach to this form):

In your own words, please describe the problem you encountered, any attempts you made to resolve it with the complained-against party, and any results/response.

VI. My complaint would be resolved to my satisfaction if: _____

_____

_____

_____

VII. Please identify any other person(s) who may have direct knowledge of the facts surrounding your complaint:

_____

_____

_____

_____

VIII. Please list any documentation that you have included to support your complaint, or describe the documentation that is available should the Board request it:

_____

_____

_____

_____

_____

_____

_____

Your Signature: _____ Date: _____

☐ Documentation is included

_____ (initial)

☐ Narrative Statement is attached

_____ (initial)

AUTHORIZATION TO RELEASE HEALTH-CARE INFORMATION TO THE STATE BOARD OF ORTHOTICS, PROSTHETICS AND PEDORTHICS

TO: _____
_____
_____
_____

_____
_____
_____
_____

This is an authorization for the above-noted individual provider, company, and/or third-party payer, to provide information upon request to the State Board of Orthotics, Prosthetics and Pedorthics, or any representative thereof, concerning professional services received on or around _____ [date or date range]. You are authorized to release any information requested identifiable with me or the identified client including, but not limited to, treatment information, services provided, progress and process notes, personal medical information including records from other health care providers, billing, claims and payment information.

This authorization is valid for 180 days. This consent to release information may be revoked at any time in writing by me, but I understand that any information received by the Board pursuant to this release prior to any such revocation may still be utilized by the Board for any lawful purpose of the Board.

Authorization signed this _____ day of _____, 200 __.

BY: signature: _____
Print name: _____
Street: _____
City, ST zip _____
Telephone: _____

If on behalf of another party:
Client/subject's name: _____
Relationship: _____
Reference information: