Ohio | Ohio Vision Professionals Board

PATIENT COMPLAINT FORM

Date: _____

Name of Complainant: _____

Address: _____
street city state zip

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

Your e-mail 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: _____

_____

FORM VPB 0118 Revised 1-29-18

77 South High Street, 16th Floor
Columbus, Ohio 43215-6108 U.S.A.
board@vision.ohio.gov
614 | 466-9709
614 | 995-5392 fax
www.vision.ohio.gov

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:

In what way(s) are the lenses unsatisfactory? _____

_____

If the problem is vision:

Do you have difficulty seeing distance? (Greater than 10 feet)_____

Do you have difficulty with near vision? (Difficulty reading, close work, etc.) _____

Are the eyeglasses uncomfortable? _____

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

Do the frames fit? _____

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

(If the answer is no, please provide a copy of the optometrist's prescription.)

Name of person or firm providing eyeglasses/contact lenses:

_____

Address: _____
street city state zip

Telephone: (___)_____

Brand name of contact lens, if available: _____

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

Type of eyeglasses; single vision, bifocal, trifocal, progressive: _____

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

What was the diagnosis of the optometrist? _____

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: (___)_____

Findings from the second eye doctor:_____

_____

_____

Medical: General state of health: Good ____ Fair ____ Poor____

Are you aware of any medical problem which may affect your eyes?
_____

_____

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 Vision Professionals Board, what do you think would be a fair solution to your complaint?

_____

_____

_____

Please Note:

If the Ohio Vision Professionals Board should find grounds for an administrative hearing, it will be necessary for you to appear as a witness under subpoena.

Please 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 us, so that appropriate action may be taken.

Information on this form 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 sections that apply to your complaint and sign the enclosed Release of Optometric/Medical Records form and return them together to:

Ohio Vision Professionals Board
77 S. High St., 16th Floor
Columbus, Ohio 43215-6108
Office: (614) 466-9709
Fax: (614) 995-5392

_____
(Signature of person filing complaint)

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

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 Vision Professionals Board any information, files, or medical records requested by the Ohio Vision Professionals Board in connection with my physical health, optometric examination, or other health problems.

I further authorize the Ohio Vision Professionals Board 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 VPB 12918 Revised 1-29-18

Ohio Vision Professionals Board

RELEASE OF OPTOMETRIC/MEDICAL RECORDS

STATE OF

COUNTY OF

I hereby authorize and request any optometrist and/or personal physician of _____ to release to the Ohio Vision Professionals Board any
(Place your name here)

information, files, or medical records requested by the Ohio Vision Professionals Board in connection with my physical health, optometric examination, or other health problems.

I further authorize the Ohio Vision Professionals Board 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.

_____
Signature of Affiant

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

_____
Signature of Official Administering Oath

SEAL

_____
Date Commission Expires_

Must be Signed and Notarized

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