DEPARTMENT OF HEALTH

PENNSYLVANIA DEPARTMENT OF HEALTH
HEARING AID PROGRAM-CONSUMER COMPLAINT FORM

MAIL TO : 132 Kline Plaza, Suite A
Harrisburg, PA 17104
717-783-8078 Fax 717-772-0232

DATE of COMPLAINT: By Mail or By Phone Taken/Processed By _____

COMPLAINANT INFORMATION:

Patient Name: _____

Address: _____
_____

City, State, Zip _____

Phone: _____

If Filed By Person other than Patient
Name:_____
Phone: _____
Relationship to Patient:_____

COMPLAINT AGAINST:

Fitter/Aud/MD Name: _____

Registration # (if known): _____
2nd Registration# (if applicable)_____

Business Name: _____

Address: _____

City, State, Zip:_____

Phone: _____
Business Owner, If different _____

PURCHASE INFORMATION: DATE OF PURCHASE: _____

# of HEARING AID(s): _____ DATE OF DELIVERY(if applicable): _____
TOTAL PURCHASE PRICE: $_____ DATE of CANCELLATION (if applicable): _____
DEPOSIT/AMT. PAID $_____
PAYMENT METHOD (circle one): Check Credit Card_____ Other: _____
WHERE SALE OCCURRED (circle one): Residence Office Other:_____

PAPERWORK/DOCUMENTATION:
Under State Law certain documentation must be provided, explained, and in some cases signed by consumer prior to the sale of any hearing aid in Pennsylvania. Please answer the following to the best of your ability.

1.Did you review and sign a one page DISCLOSURE AGREEMENT that outlined all services and goods and amount of monies refundable or nonrefundable should the hearing aids be returned or sale cancelled? _____

2. Did you review and sign a MEDICAL WAIVER or seek a physician signed medical referral? _____

3. Did you review and sign a PURCHASE RECEIPT outlining the make, model, serial number of the hearing aid selected and your rights on filing a complaint? _____

4. If IN HOME SALE, did you receive information on how to cancel within 3 business days? _____

5. Did you receive a WARRANTY on the hearing aids? _____ If so, for how long_____

6. Have you filed a complaint with any other agency or business _____ If so, with whom?

PROVIDE ADDITIONAL DETAILS REGARDING COMPLAINT & SIGN ON BACK

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DETAILS OF COMPLAINT:

MAKE SURE TO ATTACH COPIES of ALL RELEVANT PAPERWORK.

Please include any additional information you may feel is relevant. You may use additional paper if necessary.

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SIGNATURE **DATE**

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OFFICIAL USE ONLY –DO NOT COMPLETE THIS SECTION

Referred to: Program Legal AG-BCP DA PHAA BPOA DJ Corp. Manu.
Other _____

Type of Complaint: Refund/Cancellation Aids Delivery Medical Fraud Theft Conduct Ads
Other:_____

KEY ISSUES_____

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NOTIFICATION TO FITTER: _____

NOTES:_____

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FOLLOWUP/RESOLUTION_____

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