

PATIENT REQUEST FOR MEDIATION
Confidential

Upon receipt of this completed form, a mediator will be assigned and will contact you within 30 days to discuss your request and help resolve the issue. While a refund of the charges you have paid is one of the options that may be recommended by the mediator, a request for a refund should not be made in writing or on this form. This option should be addressed during the mediation process.

Patient Information:

Name: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip: _____

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

Area/Phone: _____ Time: _____

Dentist Information:

Name: _____ Area/Phone: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip: _____

Date of last appointment: _____

Describe the problem(s) specific to the dental treatment received. Attach additional sheets if needed. Please print or type:

Thank you for addressing your concerns to the South Carolina Dental Association. Please return your complaint to: **SCDA, Attn: Mediation, 120 Stonemark Lane, Columbia SC 29210**. If you have any questions in the meantime, please do not hesitate to call 800.327.2598 or 803.750.2277.

In order that a complete review is 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. I also understand that a copy of this mediation request form and all accompanying forms will be offered as explanation to the dentist who is a party to these proceedings.

 Signature

 Date