

## **CONSUMER COMPLAINT FORM**

Office of the Indiana Attorney General

To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. **DO NOT** include your **Social Security Number** on this form or in any accompanying documents.

1. YOUR INFORMATION	2. WHO IS YOUR COMPLAINT AGAINST?					
☐ Mr. ☑ Mrs. ☐ Miss ☐ Ms. ☐ Dr.  Name Cathie Humbarger  Address	Name/Firm Dr. Ulrich G. Klopfer Fort Wayne Womens Health Organization					
City Fort Wayne State IN	Address 2210 Inwood Drive					
ZIP 46835 County Allen	City Fort Wayne State IN					
Age Day	ZIP 46815 County Allen Phone ( 260 ) 471-5005					
Are you or your spouse active military?  Yes No E-mail_						
E-mail_	Person you dealt with N/A					
3. WHEN DID TRANSACTION/INCIDENT OCCUR?  Date 2/7/2013						
4. WHERE DID THE TRANSACTION/INCIDENT YOU ARE COMPLAINING ABOUT TAKE PLACE? (Check box when applicable)						
□ At the firm's place of business     □ By Mail     □ My home     □ By Internet/e-mail     □ Away from the firm's place of business (work, convention, etc.)     □ Other						
5. WHAT WAS THE VERY FIRST CONTACT BETWEEN YOU AND THE FIRM?						
☐ I telephoned the firm ☐ I responded to a TV/radio ad ☐ A person came to my home ☐ I received information by e-mail ☐ I received information in the mail	☐ I went to the firm's place of business ☐ I received a telephone call from the firm ☐ I responded to an offer on the Internet ☐ I responded to a printed advertisement ☑ Other none					
6. DO YOU CONSENT TO DISCLOSING THE FOLLOWING TO THE PUBLI	7. WHAT WAS THE TRANSACTION FOR?					
Your name?   ☑ Yes	□ No □ My business □ No □ My family/household □ My farm					
8. HOW DID YOU PAY?						
□ Cash       □ Credit Card       □ Medicaid       □ Private Insurance         □ Check       □ Installment Loan       □ Medicare       ⋈ Other						
9. DID YOU SIGN ANY WRITTEN AGREEMENT? IF YES, PLEASE ATTACH A COPY OF THE AGREEMENT.						
For Office Use Only: Ind Prac PL MO NL NJ	OA: Inv. Sec File #					

10. HAVE YOU COMPLAINED TO THE BUSINESS? (Check box when applicable)				☐ Yes	⊠No		
When?	Action taken?	)					
11. WITH WHAT OTHER AGENCY HAVE YOU FILED THIS COMPLAINT? None							
When?	Action taken?						
12. HAVE YOU CONTACTED A PRIVATE ATTORNEY?					⊠No		
13. HAVE YOU STARTED A COURT ACTION? IF YES, PLEASE ATTACH A COPY OF ALL COURT PAPERS.					⊠No		
14. HAVE YOU BEEN SUED OVER THIS ISSUE? IF YES, PLEASE ATTACH A COPY OF ALL COURT PAPERS.					⊠No		
15. DOLLAR AMOUNT ASSOCIATED WITH YOUR LOSS, IF ANY. \$	V/A						
16. PLEASE DESCRIBE YOUR COMPLAINT IN DETAIL (ATTACH ADDITIONAL PAGES IF NECESSARY)							
Please attach a copy of all papers involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence and all other related documents). Please print clearly or type. DO NOT INCLUDE YOUR SOCIAL SECURITY NUMBER.							
On 2/7/2013 Dr. Ulrich Klopfer performed an abortion on a 13 year old girl at his abortion facility, Fort Wayne Women's Health Organization, 2210 Inwood Drive, Fort Wayne, IN, 46815. This abortion was not reported to the Indiana Department of Health as required by Indiana State law (IC16-34-2-5). A copy of the termination report is attached.							
17. HOW WOULD YOU LIKE YOUR COMPLAINT RESOLVED?							
I request the immediate suspension of the medical license of Dr. Ulrich Klopfer (#02000628A) pending a full investigation.							
18. CONSENT AND VERIFICATION	<u> </u>						
I affirm, under the penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to							
other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement.  I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do							
provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).							
	9/18/13						
Your Signature	Date						
WHAT WILL HAPPEN NOW? WHAT ELSE SHOULD YOU DO?		] ]	MAIL COMPLETED FORMS	S TO:			

The Consumer Protection Division will send a copy of your complaint to the respondent firm or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

Attorney General Greg Zoeller **Consumer Protection Division** Government Center South, 5th floor 302 West Washington Street Indianapolis, IN 46204 PH: 317-232-6330 • FAX: 317-233-4393 www.IndianaConsumer.com