PATIENT SATISFACTION SURVEY

Dear Valued Patient: It is our goal to give you the best possible medical care. To do that, it is important that we know your thoughts about the care you are receiving. We need to know the areas in which we are doing well and the areas we need to improve. Your comments are strictly confidential, and results are used to accomplish quality improvement. Feel free to make any additional comments below.

Comments:_____
_____
_

Is this your first visit to our Practice? Yes _____ No _____ Or a return visit? Yes_____ No_____

Was it easy to schedule an appointment with our Practice? Yes_____ No_____
Comments: _____

When you called:
The phone was answered promptly Yes_____ No_____
I was placed on hold temporarily Yes_____ No_____
Comments:_____

Was the person answering the phone pleasant? Yes_____ No_____
Comments: _____

Was the availability of appointment times reasonable? Yes_____ No_____
Comments: _____

Which provider are you seeing today? Please circle one.

Drs. McWilliams, Chow, Zimmerman, James, Laws, Cashman

Anna McKie, PA-C, April McNeill, PA-C

Why did you seek medical treatment at this Practice?
Please check all that apply.

Referred by another provider Yes_____ No_____
Referred by another patient Yes_____ No_____
Selected physician from insurance list Yes_____ No_____
Other: _____

Do you find the appearance of the office pleasant? Yes _____ No _____
Comments: _____

Was your waiting time to see the provider reasonable? Yes _____ No _____
Comments: _____

Was the doctor's explanation of your evaluation, diagnosis options and treatment options easy for you to understand?
Were your questions completely answered? Yes_____ No_____
Comments: _____

Were you satisfied with the time the provider spent with you? Yes_____ No_____
Comments: _____

Did you find the clinical staff professional, knowledgeable, and helpful? Yes _____ No _____
Comments: _____

Did you find our front desk receptionists professional, knowledgeable, and helpful? Yes _____ No _____
Comments: _____

Were you satisfied with the overall visit/ medical treatment you received at this Practice? Yes_____ No_____
Comments: _____

Would you recommend this Practice to others? Yes_____ No_____
Comments: _____

What do we need to change to improve our service to patients? _____

If you would like our Administrator to contact you to discuss your feedback, please complete the following:

Patient's Name Optional)
_____

Patient's Address (Optional) _____

Patient's Phone Number (Optional) _____