Patient Satisfaction Survey

Location of your visit:

☐ Salemville ☐ Johnson City ☐ Carson ☐ Olathe

	Y	N
Is this your first visit?	☐	☐

Which department was your appointment with (choose one)?

○ Family Practice	○ Internal Medicine	○ Pediatrics	○ OB/GYN
○ Ortho	○ Eye	○ Radiology	○ Laboratory
○ Physical Therapy	○ Other		

Name of physician your appointment was with? .....

	Y	N
Would you like a clinic representative to contact you about your visit?	☐	☐

If yes, print your name here

and phone number here ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

Before Your Visit

Response Definition: P=Poor F=Fair G=Good VG=Very Good E=Excellent

	P	F	G	VG	E
1. Ease of scheduling appointments	☐	☐	☐	☐	☐
2. Friendliness of appointment scheduler	☐	☐	☐	☐	☐
3. Convenience of our clinic hours	☐	☐	☐	☐	☐
4. Ease reaching your physician's nurse by phone, during office hours, with questions regarding your condition	☐	☐	☐	☐	☐
5. Promptness of nursing staff in returning your calls	☐	☐	☐	☐	☐
6. Availability of parking	☐	☐	☐	☐	☐
7. Timeliness of registration process	☐	☐	☐	☐	☐
8. Courtesy shown by registration and reception staff	☐	☐	☐	☐	☐
9. Satisfaction with length of time between registration and exam	☐	☐	☐	☐	☐
10. Explanation of any prolonged wait if applicable	☐	☐	☐	☐	☐

Response Definition: 5=0-5 minutes 6=6-10 minutes 11=11-15 minutes 16=16-20 minutes 21=21 minutes or longer

	5	6	11	16	21
11. Time waited between registration and exam	☐	☐	☐	☐	☐
12. Cleanliness of clinic environment	☐	☐	☐	☐	☐

The Care You Received

13. Respect of your privacy	☐	☐	☐	☐	☐
14. Friendliness and concern of your care provider (physician, nurse practitioner, physician asst)	☐	☐	☐	☐	☐
15. Opportunity to discuss your concerns/issues with your physician/care provider	☐	☐	☐	☐	☐

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	P	F	G	VG	E
16. Satisfaction that all your questions were adequately addressed	☐	☐	☐	☐	☐
17. Adequate time spent with physician/care provider	☐	☐	☐	☐	☐
18. Your involvement in deciding upon treatment options	☐	☐	☐	☐	☐
19. Clear instructions for your treatment, ongoing care at home or follow-up	☐	☐	☐	☐	☐
20. Discussion about wellness and health maintenance	☐	☐	☐	☐	☐
21. Your sense of trust in your physician/care provider	☐	☐	☐	☐	☐
22. Overall care and concern provided by physician/care provider	☐	☐	☐	☐	☐
23. Overall care and concern provided by nurse	☐	☐	☐	☐	☐
24. Friendliness and professionalism of lab staff	☐	☐	☐	☐	☐
25. Friendliness and professionalism of x-ray staff	☐	☐	☐	☐	☐
26. Friendliness and professionalism of physical therapy staff	☐	☐	☐	☐	☐
27. Friendliness and professionalism of nursing staff	☐	☐	☐	☐	☐

After Your Visit

	P	F	G	VG	E
28. Notification of any test results	☐	☐	☐	☐	☐
29. Your overall rating of the clinic	☐	☐	☐	☐	☐
30. Likelihood you would recommend our clinic to others	☐	☐	☐	☐	☐

31. Please share any additional comments or suggestions about how we can improve the service you received.

Please refold and seal with tape on bottom before mailing. Postage is already paid. Thank you.

PHYSICIAN-ID

MONTH