Provider **Date**

Dear Patient: Our goal is to provide comfort, convenience, and the very best medical care to all our patients. We'd like to know how you feel about our medical services, patient-handling systems, physicians and staff members. Your comments will help us evaluate our operations to ensure that we are truly responsive to your needs. Thank you for your help.

PLEASE RATE THE FOLLOWING:	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
A. YOUR APPOINTMENT:						
1. Ease of making appointments by phone	5	4	3	2	1	N/A
2. Appointment available within a reasonable amount of time	5	4	3	2	1	N/A
3. Getting care for illness/injury as soon as you needed it	5	4	3	2	1	N/A
4. Getting after-hours care when you needed it	5	4	3	2	1	N/A
5. The efficiency of the check-in process	5	4	3	2	1	N/A
6. Waiting time in the reception area	5	4	3	2	1	N/A
7. Waiting time in the exam room	5	4	3	2	1	N/A
8. Ease of getting a referral when you needed one	5	4	3	2	1	N/A
B. OUR STAFF:						
1. The courtesy of the person who took your call	5	4	3	2	1	N/A
2. The friendliness and courtesy of the receptionist/office staff	5	4	3	2	1	N/A
3. The helpfulness of the receptionist/office staff	5	4	3	2	1	N/A
4. Keeping you informed if your appointment time was delayed	5	4	3	2	1	N/A
5. The caring concern of our nurses/medical assistants/lab	5	4	3	2	1	N/A
6. The professionalism of our ultrasound, mammography and bone density staff	5	4	3	2	1	N/A
C. OUR COMMUNICATION WITH YOU:						
1. Your phone calls answered promptly	5	4	3	2	1	N/A
2. Clear and concise phone communications	5	4	3	2	1	N/A
3. Getting advice or help when needed during office hours	5	4	3	2	1	N/A
4. Answering your questions in a way that was easy to understand	5	4	3	2	1	N/A
5. Your test results reported in a reasonable amount of time	5	4	3	2	1	N/A
6. Effectiveness of our patient education materials	5	4	3	2	1	N/A
7. Our ability to return your calls in a timely manner	5	4	3	2	1	N/A
8. Your ability to contact us after hours	5	4	3	2	1	N/A
9. Your ability to obtain prescription refills	5	4	3	2	1	N/A

PLEASE COMPLETE THE OTHER SIDE →

Form: CMD1 Site: 1

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D. YOUR VISIT WITH THE PROVIDER: (Doctor, Nurse Practitioner)	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
1. Willingness to listen carefully to you	5	4	3	2	1	N/A
2. Taking time to answer your questions	5	4	3	2	1	N/A
3. Amount of time spent with you	5	4	3	2	1	N/A
4. Explaining things in a way you could understand	5	4	3	2	1	N/A
5. Instructions regarding medication/follow-up care	5	4	3	2	1	N/A
6. The thoroughness of the examination	5	4	3	2	1	N/A
7. Advice given to you on ways to stay healthy	5	4	3	2	1	N/A
8. Knowledge of important information about your medical history	5	4	3	2	1	N/A
9. Showing respect for what you had to say	5	4	3	2	1	N/A
10. Including you in decision-making about your treatment plan	5	4	3	2	1	N/A
E. BILLING:						
1. Helpfulness of people who assisted you with billing/insurance	5	4	3	2	1	N/A
2. Clarity of the billing statement	5	4	3	2	1	N/A
3. Accuracy of the billing statement	5	4	3	2	1	N/A
4. Promptness in resolving billing/insurance questions or problems	5	4	3	2	1	N/A
F. OUR FACILITY:						
1. Hours of operation convenient for you	5	4	3	2	1	N/A
2. Overall comfort	5	4	3	2	1	N/A
3. Adequate parking	5	4	3	2	1	N/A
4. Signage and directions easy to follow	5	4	3	2	1	N/A
G. YOUR OVERALL SATISFACTION WITH:						
1. Our practice	5	4	3	2	1	N/A
2. The quality of your medical care	5	4	3	2	1	N/A
3. Overall rating of care from your provider	5	4	3	2	1	N/A
	Definitely Yes	Probably Yes	Don't Know	Probably Not	Definitely Not	
4. Would you recommend the provider to others?	5	4	3	2	1	

(Please circle)

IF NO, PLEASE TELL US WHY: ____

____

IF THERE IS ANY WAY WE CAN IMPROVE OUR SERVICES TO YOU, PLEASE TELL US ABOUT IT:

____

____

WOULD YOU LIKE TO RECOGNIZE ANYONE WHO PROVIDED OUTSTANDING SERVICE TODAY?

ARE YOU:

__ A new patient?

__ A returning patient?

Employee Name

May we contact you to follow up? ___yes ___no

If yes, please provide your name and number below.

Thank you very much for your help!

Name________________________Number_______________

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