



Patient Satisfaction Survey

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

PLEASE RATE THE FOLLOWING:

	Excellent	Very Good	Good	Fair	Poor	Not Applicable
A. YOUR APPOINTMENT						
1. Ease of making appointments by phone	5	4	3	2	1	N/A
2. Appointment availability	5	4	3	2	1	N/A
3. Efficiency of the check-in process	5	4	3	2	1	N/A
4. General knowledge/competence of the reception area staff	5	4	3	2	1	N/A
5. Waiting time in the reception area	5	4	3	2	1	N/A
6. Waiting time in the exam room	5	4	3	2	1	N/A
7. Notification if your appointment time was delayed	5	4	3	2	1	N/A
8. Ease of getting a referral when you need one	5	4	3	2	1	N/A
9. Privacy: how well your privacy was considered	5	4	3	2	1	N/A
B. OUR STAFF						
1. Courtesy of the person who took your call	5	4	3	2	1	N/A
2. Friendliness and courtesy of the receptionist	5	4	3	2	1	N/A
3. Quality of care of medical assistants	5	4	3	2	1	N/A
4. Helpfulness of the people in our billing office	5	4	3	2	1	N/A
C. OUR COMMUNICATION WITH YOU						
1. Promptness answering phone calls	5	4	3	2	1	N/A
2. Availability of medical information/advice by telephone	5	4	3	2	1	N/A
3. Explanation of your procedure (if applicable)	5	4	3	2	1	N/A
4. Reporting test results in a reasonable amount of time	5	4	3	2	1	N/A
5. Effectiveness of our health information materials	5	4	3	2	1	N/A
6. Ability to return your calls in a timely manner	5	4	3	2	1	N/A
7. Keeping you informed of doctor delays	5	4	3	2	1	N/A
8. Response time of staff to your comfort and care during doctor delays	5	4	3	2	1	N/A
9. Ability to contact us after hours	5	4	3	2	1	N/A

Please complete the other side.

		Very				Not
Excellent	Good	Good	Fair	Poor	Applicable	

D. YOUR VISIT WITH THE DOCTOR

1. How well the doctor listened to you	5	4	3	2	1	N/A
2. Satisfaction with answers to your questions	5	4	3	2	1	N/A
3. Quality of interaction with the doctor	5	4	3	2	1	N/A
4. Explanation of treatment options	5	4	3	2	1	N/A
5. Doctor's instructions regarding medication/follow-up care	5	4	3	2	1	N/A
6. Thoroughness of the initial visit examination	5	4	3	2	1	N/A
7. Satisfaction of treatment prescribed by your doctor	5	4	3	2	1	N/A

E. OUR FACILITY

1. Appearance of the office	5	4	3	2	1	N/A
2. Convenience of hours of operation	5	4	3	2	1	N/A
3. Overall comfort	5	4	3	2	1	N/A
4. Parking	5	4	3	2	1	N/A
5. Signage and directions	5	4	3	2	1	N/A

F. WOULD YOU RECOMMEND THE DOCTOR TO OTHERS? Yes No

If no, please tell us why: _____

G. If there is any way we can improve our services to you, please tell us about it:

H. How did you find out about this office? (Please check one.)

- _____ Physician referral
- _____ Friend or family member referral
- _____ Circle one: **Internet Newspaper Magazine** Please specify web site/newspaper: _____
- _____ Chiropractor referral
- _____ Found the doctor in my medical plan's provider listing

Today's Date: _____

Office you visited (Please Circle One):

Duxbury *Wellesley* *Dedham* *West Yarmouth* *Mashpee*

Your Name (Optional): _____