

CopperView Medical Center

Patient Satisfaction Survey

We would very much appreciate your completing this questionnaire. Your evaluation will help us improve our services. When you have finished, please mail it in the enclosed envelope. Thank you in advance!

BACKGROUND QUESTIONS (write in answer or check as appropriate)

- | | |
|---|---|
| <p>1. Date of visit:</p> <p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> _____ Month Day Year </p> <p>2. Time of day you arrived:</p> <p> <input type="checkbox"/> 8:00 am - 11:00 am <input type="checkbox"/> 11:01 am - 3:00 pm <input type="checkbox"/> 3:01 pm - 7:00 pm <input type="checkbox"/> 7:01 pm - 10:00 pm </p> <p>3. Patient's gender <input type="checkbox"/> Male <input type="checkbox"/> Female</p> | <p>4. Patient's age..... _____</p> <p>5. Who is filling out this survey?</p> <p> <input type="checkbox"/> Patient <input type="checkbox"/> Friend <input type="checkbox"/> Parent <input type="checkbox"/> Other <input type="checkbox"/> Family </p> <p>6. May we contact you about your visit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|---|

INSTRUCTIONS: Please rate the Department services you received from our facility. Check the appropriate response which describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad experiences that may have happened to you.

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|----------------------------------|-------------------|-----------|-----------|-----------|-------------------|
| A. APPOINTMENT SCHEDULING | | | | | |

- | | | | | | |
|---|-------|-------|-------|-------|-------|
| 1. Courtesy and professionalism of the person who answered the phone | _____ | _____ | _____ | _____ | _____ |
| 2. Ease with which you were able to schedule an appointment with the provider of your choice at a convenient time for you | _____ | _____ | _____ | _____ | _____ |

Comments (describe good or bad experience) _____

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|-------------------|-------------------|-----------|-----------|-----------|-------------------|
| B. ARRIVAL | | | | | |

- | | | | | | |
|--|-------|-------|-------|-------|-------|
| 1. Courtesy and professionalism of reception | _____ | _____ | _____ | _____ | _____ |
| 2. Courtesy and knowledge of the person who took your personal/insurance information | _____ | _____ | _____ | _____ | _____ |

| ARRIVAL <i>(continued)</i> | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|-----------------------------------|-------------------|-----------|-----------|-----------|-------------------|
|-----------------------------------|-------------------|-----------|-----------|-----------|-------------------|

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|---|-------|-------|-------|-------|-------|
| 3. Privacy you felt when asked about your personal/insurance information | _____ | _____ | _____ | _____ | _____ |
| 4. Ease of giving your personal/insurance information | _____ | _____ | _____ | _____ | _____ |
| 5. Comfort of the waiting area | _____ | _____ | _____ | _____ | _____ |
| 6. Waiting time before you were taken to the treatment area | _____ | _____ | _____ | _____ | _____ |
| 7. Waiting time in the treatment area before you were seen by a healthcare provider | _____ | _____ | _____ | _____ | _____ |

Comments (describe good or bad experience) _____

| C. MEDICAL ASSISTANTS | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|------------------------------|-------------------|-----------|-----------|-----------|-------------------|
|------------------------------|-------------------|-----------|-----------|-----------|-------------------|

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|---|-------|-------|-------|-------|-------|
| 1. Courtesy of the medical assistants | _____ | _____ | _____ | _____ | _____ |
| 2. Degree to which the medical assistants took the time to listen to you | _____ | _____ | _____ | _____ | _____ |
| 3. Medical assistants' attention to your needs | _____ | _____ | _____ | _____ | _____ |
| 4. Medical assistants' concern for your privacy | _____ | _____ | _____ | _____ | _____ |
| 5. Medical assistants' skill when administering injections or performing other procedures | _____ | _____ | _____ | _____ | _____ |

Comments (describe good or bad experience) _____

| D. DOCTORS/HEALTHCARE PROVIDERS | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|-------------------|-----------|-----------|-----------|-------------------|
|--|-------------------|-----------|-----------|-----------|-------------------|

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|---|-------|-------|-------|-------|-------|
| 1. Courtesy of provider | _____ | _____ | _____ | _____ | _____ |
| 2. Degree to which the provider took the time to listen to you | _____ | _____ | _____ | _____ | _____ |
| 3. Provider's concern to keep you informed about your condition and treatment | _____ | _____ | _____ | _____ | _____ |
| 4. Provider's concern for your comfort while treating you | _____ | _____ | _____ | _____ | _____ |

D. DOCTORS/HEALTHCARE PROVIDERS *(continued)*

Comments (describe good or bad experience) _____

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|-------------------|-----------|-----------|-----------|-------------------|
|--|-------------------|-----------|-----------|-----------|-------------------|

(Please answer only those questions which apply to you)

Lab

- | | | | | | |
|---|-------|-------|-------|-------|-------|
| 1. Waiting time for lab | _____ | _____ | _____ | _____ | _____ |
| 2. Courtesy of the person who took your blood | _____ | _____ | _____ | _____ | _____ |
| 3. Concern shown for your comfort when your blood was drawn | _____ | _____ | _____ | _____ | _____ |
| 4. Notification of lab results. | _____ | _____ | _____ | _____ | _____ |

Radiology (X-ray)

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|--|-------|-------|-------|-------|-------|
| 1. Waiting time for radiology test | _____ | _____ | _____ | _____ | _____ |
| 2. Courtesy of the radiology staff | _____ | _____ | _____ | _____ | _____ |
| 4. Concern shown for your comfort during your test | _____ | _____ | _____ | _____ | _____ |

Comments (describe good or bad experience) _____

| | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|--|-------------------|-----------|-----------|-----------|-------------------|
|--|-------------------|-----------|-----------|-----------|-------------------|

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|---|-------|-------|-------|-------|-------|
| 1. How well you were kept informed about delays | _____ | _____ | _____ | _____ | _____ |
| 2. Degree to which staff cared about you as a person | _____ | _____ | _____ | _____ | _____ |
| 3. How well your pain was controlled during your visit | _____ | _____ | _____ | _____ | _____ |
| 4. Information you were given about caring for yourself at home (e.g., medications, follow-up medical care) | _____ | _____ | _____ | _____ | _____ |

Comments (describe good or bad experience) _____

| G. AFTER THE VISIT | very poor 1 | poor 2 | fair 3 | good 4 | very good 5 |
|---------------------------|-------------------|-----------|-----------|-----------|-------------------|
|---------------------------|-------------------|-----------|-----------|-----------|-------------------|

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|---|-----|-----|-----|-----|-----|
| 1. How promptly and accurately your insurance company was billed | ___ | ___ | ___ | ___ | ___ |
| 2. Degree to which the staff answered any billing questions | ___ | ___ | ___ | ___ | ___ |
| 3. How promptly outside procedures (e.g. CAT scans, MRI, ultrasound) were scheduled and you were informed (answer only if applicable) | ___ | ___ | ___ | ___ | ___ |
| 4. The efficiency with which staff referred you to specialists (e.g. orthopedics, pulmonary) and the promptness of notifying you | ___ | ___ | ___ | ___ | ___ |
| 5. How well staff answered medical questions, scheduled follow-up appointments and called out prescriptions. | ___ | ___ | ___ | ___ | ___ |

Comments (describe good or bad experience) _____

| H. OVERALL ASSESSMENT | very poor 1 | fair 2 | good 3 | good 4 | very good 5 |
|------------------------------|-------------------|-----------|-----------|-----------|-------------------|
|------------------------------|-------------------|-----------|-----------|-----------|-------------------|

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|--|-----|-----|-----|-----|-----|
| 1. Overall rating of care received during your visit | ___ | ___ | ___ | ___ | ___ |
| 2. Likelihood of your recommending CopperView Medical Center to others | ___ | ___ | ___ | ___ | ___ |

Comments (describe good or bad experience) _____

Patient's Name: *(optional)* _____

Telephone Number: *(optional)* _____