Your Physician's Name: _____ Date: _____

Please take a few minutes to fill out this survey on the quality of service you received before and during your visit.

Your answers will be kept confidential

Description	Very Poor 1	Poor 2	Fair 3	Good 4	Very Good 5	Does not apply NA
• Front Desk Reception and Check-Out Staff were Courteous, Compassionate, and Helpful						
• Nursing Staff were Courteous, Compassionate, and Helpful						
• Promptness of Phone Call-back from Doctor or Nurse During Office Hours						
• Promptness of Phone Call-back from On-call Doctor After Hours						
• The Ease of Your Call Being Answered by a Staff Person When you Called for an Appointment or Other Service						
• Satisfaction with the Length of Time Between the day the Appointment was made and the Day of the Visit						
• Overall Satisfaction with Your Wait Time from Time of Arrival Until seen by a Doctor						
• Overall Satisfaction with the Amount of Time the Doctor Spent with You						
• Satisfaction with Your Doctors Care and Communication with You Regarding Your Medical Condition						
• Overall confidence in your ability to manage your health or condition						
• Confidence in Your Doctor to Refer You to a Specialist if Necessary						
• Likelihood of Recommending this Practice to Others						
• Overall Satisfaction with Your Most Recent Visit						
• Convenience of Office Hours						
• Overall satisfaction with your child's specialty visit						
• If your child was seen by a specialist, please list the provider name and clinic: _____						
• Overall satisfaction wit your use of community resources provided by the practice (i.e. breastfeeding, asthma education, parenting, internet safety, parent decision making aids, weight management obtaining discount prescription medications).						

Comments/Suggestions: _____